

INCREASING THE AWARENESS OF MENTAL HEALTH
TO THE LEADERSHIP AND CONGREGATION
OF THE JUBILEE COMMUNITY CHURCH

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ABSTRACT

INCREASING THE AWARENESS OF MENTAL HEALTH TO THE LEADERSHIP AND CONGREGATION OF THE JUBILEE COMMUNITY CHURCH

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Over the past few years, the demand for mental health services has increased. As the Assistant Pastor at Jubilee Community Church, I have particularly observed its effects during spiritual counseling sessions. My hypothesis is this: “If ministry leaders are trained to recognize the signs of distress (anxiety and depression), then they will be equipped to exercise compassion and guide congregants to the help they need.” My project aims to gauge the interest of ministry leaders in participating in training, which will reveal their willingness to serve as resources. A six-week overview on mental health will be conducted.

ACKNOWLEDGEMENTS

I want to sincerely thank everyone who helped me complete my thesis. To my mentor professors, your insights and encouragement have been invaluable. I am grateful to all the professors who shared additional insights during the intensive weeks in pursuit of academic excellence. To my cohort, the staff at United Theological Seminary, and everyone who supported me along this journey, I truly appreciate you.

DEDICATION

I dedicate my dissertation to my family, many friends, and the countless individuals who offered words of encouragement. I also want to thank a very special person who has been with me in spirit: thank you, Robert Lewis, for your words, “Why not you,” which inspire me to never give up on what’s possible.

ABBREVIATIONS

APA	American Psychological Association
JCC	Jubilee Community Church
SIT	Social Identity Theory
WHO	World Health Organization

“Anything that’s human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary.”

– Fred Rogers

INTRODUCTION

The parable of the “Good Samaritan” found in Luke 10:25-37 provides instruction on the responsibilities of caring for each other, emphasizing that care is not limited to any one individual but extends to everyone. In this scripture, Jesus seeks to enlighten a law expert on what love truly encompasses. Specifically, when Jesus asks the law expert, “What is written in the law?” he correctly responds, “Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind;” and, “Love your neighbor as yourself.” Love is not confined to just physical well-being; it also includes a commitment to the emotional and spiritual well-being of others.

Jesus used a parable to bring understanding to the meaning of not only the letter of the law but also the actions that accompany its meaning. In His illustration, He presented several individuals, including the church hierarchy, an innkeeper, and an injured person. The representation of the Priest and the Levite demonstrates that everyone has a responsibility to assist others. This is significant because the roles of the Priest and the Levite, as they pertained to Levitical law, included specific instructions and restrictions. Their work was specific to temple service. However, when it comes to human needs, everyone has the responsibility to assist where they can, and human needs should take priority over religious obligations.

Although the phrase “mental health” is not found in biblical literature, the behaviors and actions of many mentioned within its pages suggest that biblical authors

were aware of its existence and impact. Countless scriptures offer readers support and comfort, which can bring peace to those who are troubled. Furthermore, while Jesus did not explicitly speak about mental health, His teachings--especially the Parable of the Samaritan (Luke 10:25-37)--remain relevant to the Church's response to mental health today.

It is important to understand that in the parable of the Good Samaritan, scripture does not indicate that he was "good," only that he was a Samaritan. This suggests that anyone has the responsibility to render aid and compassion to someone in need. The Samaritan could be anyone--not necessarily a believer--but simply someone who saw a need and chose to assist.

The overarching theme of the Samaritan parable may seem obvious: love for others. However, as the parable reveals, love requires action. It is the kind of love that God expressed when He gave His Son as an atoning sacrifice for the sins of humanity (John 3:16). Love should especially inspire Christ's followers to serve others.

The very format of the teaching—a parable—encourages deeper reflection on how we respond to what we encounter in our everyday lives. Jesus strategically guides the lawyer in this parable to consider not only the letter of the law but also the meaning of God's greatest commandments: "'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbor as yourself'" (Matt. 22:37-39).¹

This pericope of scripture reveals that obedience to God entails a responsibility to address the needs of others. It challenges readers to consider their actions and internal

¹ All Bible verses are taken from the New International Version (NIV).

motivations as they interact with or avoid others. Our obedience to God's commands should be demonstrated in what we do. Ignoring the needs of others—including mental health needs—means ignoring God's commands.

The Bible should be taught with special care, focusing on being contextually sound. It should inspire the listener to desire to follow God's laws and provide compassionate care. Sound Biblical teachings on mental health can motivate congregants to assist their fellow brothers and sisters selflessly. Incorporating biblical sermons and teachings that focus on mental health can raise awareness to help remove the stigma surrounding mental health and encourage those who might not consider seeking mental health care to reconsider. While it may not be possible to predetermine a person's need, observing or hearing about a need can lead to action, and that action is not for ourselves but for God. As Paul taught, "Whatever you do, work at it with all your heart, as working for the Lord, not for human masters" (Col. 3:23).

Historical

As mental health awareness has increased, there is a greater need for solutions. The Salvation Army is an organization that has unknowingly aided the mental health of many. William Booth, the founder of the Salvation Army, believed that individuals showing signs of mental disturbance should be placed in asylums. During Booth's time, the attitude toward mental health was inhumane. It was not until the mid-twentieth century that perceptions of mental health began to shift. However, William Booth, through his initiative to bring salvation to urban areas, recognized that preaching salvation would not be effective in the presence of homelessness, starvation, unwed

mothers, prostitution, and other issues, all of which we now understand to be signs of mental distress.

Maslow's hierarchy of needs, the essential needs that drive human behavior, was not being met. To fulfill Booth's objective of saving souls, he first had to address these needs. Booth needed to recognize the necessity, and it was when he ventured into the streets of London that he observed the plight of those living there. This observation led him to establish soup kitchens and shelters, create employment opportunities, and devise a plan to tackle poverty. Initiatives like this address mental health needs by supporting the emotional well-being of those suffering, alleviating stress, and fostering healthy relationships, which provide people with a sense of purpose that contributes to mental health.

William Booth, the founder of The Salvation Army, exemplifies a Christian response to mental health. He witnessed the widespread impact of distress in urban England during the 1800s. His initiative illustrates the importance of recognizing a need. As he ventured into the community, he observed a distressed environment marked by poverty and suffering individuals. Although helping those in distress was not his initial intent, what he encountered moved him to compassion and drove him to take action. Booth, much like the Samaritan, approached those he saw in pain and provided what he could—food, clothing, shelter, and more—to help alleviate their suffering. He combined evangelistic outreach with practical material care. This approach encouraged those who received assistance to join what would later be known as the Salvation Army. Today, over a century later, the Army has expanded globally, with 1.8 million members offering numerous services in 134 countries.

William Booth's response to the suffering he witnessed was driven by his faith in and love for God, demonstrating that intentional acts can make a difference, which involves loving your neighbor as yourself. Examining the history of The Salvation Army provides a model for engagement and an opportunity to address the physical, emotional, mental, and spiritual needs of others, thereby helping to remove the stigma surrounding mental health and encouraging more individuals to seek help.

Theological

The Church consists of human beings with an inherent capacity to care for others. It is made up of individuals created in God's image who possess His Spirit. God breathed His breath into humankind (Gen. 2:7). Thus, we have a part of Him within us, enabling us to see, hear, and understand His will. The theological implications of studying mental health include acknowledging the Church's role in supporting others.

Scripture affirms that we should view others through the eyes of God. Paul teaches, "In your relationships with one another, have the same mindset as Christ Jesus: Who, being in very nature God, did not consider equality with God something to be used to his own advantage; rather, he made himself nothing by taking the very nature of a servant, being made in human likeness. And being found in appearance as a man, he humbled himself by becoming obedient to death—even death on a cross!" (Phil. 2:5-8). Jesus demonstrated His love through humility and service, embodying the role of a servant as an example for all who follow Him.

Ecclesiology is not merely a single concept; it is the study of the Church, encompassing its disciplines, leadership, and relationship with Christ, following His

actions. It involves understanding the origins of Christianity and the process by which Christians collectively grow in faith and serve others. Scripture teaches that gathering in physical spaces is beneficial for building each other up: “And let us consider how we may spur one another on toward love and good deeds, not giving up meeting together, as some are in the habit of doing, but encouraging one another—and all the more as you see the Day approaching” (Heb. 10:24-25).

Building each other up solely for personal gain is selfish and self-centered. The church should be a place where teaching, preaching, and guidance occur, with this knowledge shared both inside and outside the church building. Education about mental health is as crucial as other teachings and can help people understand the complexities of how God created us, emphasizing that mental health is just as vital as any other aspect of their lives.

The work of the Church extends beyond the walls of a building. Inside, you can discover what it means to love as Jesus loved, to love unconditionally, and also to learn the purpose of the Church, how to serve with humility, and how to apply what you learn in the world. Church leaders are called to embody Christ in the flesh and fulfill His commands, especially the command to love everyone without discrimination.

Interdisciplinary

Humans are complex. Social Identity Theory (SIT) highlights the benefits of maintaining a healthy social network and explains how individuals derive a sense of identity from group membership. This theory suggests that people attain their identity through belonging to a group. These groups shape behavior and provide a sense of

belonging, which can alleviate distress. SIT influences how individuals perceive themselves, fostering a sense of well-being. However, there is not only social identity but also individual identity—an identity that is biological, such as race and ethnicity, or inherent, like blood type and certain physical features. The absence of social identity has been linked to stress, anxiety, and depression, all of which contribute to poor mental health.

With loneliness and isolation being significant factors in the rise of mental health issues, possessing a strong sense of identity can alleviate distress. Being part of a group enhances self-worth and fosters connections with others. Amid growing concerns about mental health, belonging to a group can decrease the number of individuals who feel isolated and alone. Healthy social connections promote effective coping strategies that bolster mental health by providing a sense of belonging. Developing a social identity through group membership within the Church offers support and opportunities to learn from others.

CHAPTER ONE

MINISTRY FOCUS

Introduction

“One in five Americans experiences a mental health disorder in any given year.”¹ While records of mental disorders date back to 500 BC,² mental health as a discipline or practice did not emerge until 1946.³ The worldwide COVID-19 pandemic stretching from late 2019 through early 2023 elevated public awareness of issues involving psychological, emotional, and social well-being and how they function specific to mental health (not to be confused with mental illness).⁴ Safety measures, including “shelter-in-place” (SIP), led to isolation which negatively impacted mental health and subsequently increased the number of individuals dealing with mental health issues.⁵ The Kaiser

¹ Erin Connors. “Words Matter: Reporting on Mental Health Conditions.” American Psychiatric Association. <https://www.psychiatry.org/news-room/reporting-on-mental-health-conditions>.

² Richard Seefeldt. *Psychological Disorders: A Unit Lesson Plan for High School Psychology Teachers* (Washington, DC: American Psychological Association, 2014).

³ José Bertolote. “The Roots of the Concept of Mental Health.” *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)* 7, no. 2 (2008): 113, doi:10.1002/j.2051-5545.2008.tb00172.x.

⁴ “About Mental Health.” Mental Health. Centers for Disease Control. <https://www.cdc.gov/mentalhealth/learn/index.htm>.

⁵ Alexiss Jeffers et al. “Impact of Social Isolation During the COVID-19 Pandemic on Mental Health, Substance Use, and Homelessness: Qualitative Interviews with Behavioral Health Providers.” *International Journal of Environmental Research and Public Health* 19, no. 19 (2022): 12120. <https://doi.org/10.3390/ijerph191912120>.

Family Foundation reported “that 47% of those sheltering in place reported negative mental health effects resulting from worry or stress related to COVID-19.”⁶

Still, mental health concerns existed before the 2019 pandemic. The pandemic primarily highlighted the need to discuss mental health and how to support those who are suffering. This is especially critical because “Far more than any other type of illness, mental disorders are subject to negative judgments and stigmatization.”⁷ Unfortunately, the stigma associated with mental disorders prevents individuals suffering from them from seeking help. With this broadly held negative perception, people who struggle with their mental health often suffer in silence.

Despite the increasing public awareness of mental health and mental illness, misunderstandings about them persist, contributing to stigma. Mental health is often used interchangeably with mental illness. However, they are not the same. Mental health, a holistic term, “includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.”⁸ While mental health may appear to be an individual concern because it is “key to relationships, personal and emotional well-being, and contributing to community or society,”⁹ it has broad societal implications. Major social problems,

⁶ Changwon Son, Sudeep Hegde, Alec Smith, Xiaomei Wang, and Farzan Sasangohar, “Effects of COVID-19 on College Students' Mental Health in the United States: Interview Survey Study,” *Journal of Medical Internet Research* 22, no. 9 (September 2020): 1422-1435. <https://www.jmir.org/2020/9/e21279/>.

⁷ N. Oexle et al., “Mental Illness Stigma, Secrecy and Suicidal Ideation,” *Epidemiology and Psychiatric Sciences* 26, no. 1 (February 2017): 53-60.

⁸ Centers for Disease Control, “About Mental Health.”

⁹ Ihuoma Njoku, “What is Mental Illness?” Patients and Families, American Psychiatric Association, November 2022, <https://www.psychiatry.org/patients-families/what-is-mental-illness>.

including domestic violence, gun violence, mass shootings, and childhood trauma, are often interconnected with mental health and illness.

In contrast to mental health, mental illness involves a diagnosable condition. The American Psychiatric Association explains, “Mental illnesses take many forms. Some are mild and interfere in limited ways with daily life, such as some phobias (abnormal fears). Other mental health conditions are so severe that a person may need care in a hospital.”¹⁰

Many factors can negatively impact mental health and contribute to mental illness, including childhood abuse and trauma, neglect, loneliness and isolation, discrimination, racism, illness, stress, social disadvantage, poverty, debt, long-term illness, addiction, long-term caregiving, homelessness, grief, depression, and more. Genetics may also play a role. According to the Centers for Disease Control and Prevention (CDC), “many mental disorders result from the complex interplay of multiple genes with diverse environmental factors.”¹¹ Importantly, “even for those with genetic risk . . . environmental factors can play a significant role in whether or not a person develops a disorder or the severity of an illness.”¹² Environmental factors contributing to overall mental health may include neighborhood drug use, shootings, riots, and a parent or guardian’s family history.

“One out of every two people in the world will develop a mental health disorder in their lifetime, according to a large-scale study co-led by researchers from Harvard

¹⁰ Njoku, “What is Mental Illness?”

¹¹ Centers for Disease Control and Prevention, “Mental Health Awareness,” January 20, 2011, <https://www.cdc.gov/genomics/resources/diseases/mental.htm>.

¹² Centers for Disease Control and Prevention, “Mental Health Awareness.”

Medical School and the University of Queensland.”¹³ Mental illness is indiscriminate, yet according to Pew Research, “women are much more likely than men to experience psychological distress (48% vs. 32%).”¹⁴ Researchers hypothesize that “Social and economic factors can put women at greater risk of poor mental health than men.”¹⁵

In addition to the stigma surrounding mental health, those experiencing mental illness may encounter other barriers to care, such as financial obstacles. For example,

Before passage of the MHPAE (Mental Health Parity and Addiction Equity), coverage for behavioral health care often required a higher level of cost-sharing (e.g., coinsurance of 50 percent compared with 20 percent for outpatient medical services) and special service limits (e.g., twenty outpatient visits and thirty inpatient days per year).¹⁶

Individuals with mental health symptoms faced higher insurance premiums than others. This led some to choose to be uninsured or to withhold disclosure of their medical conditions, putting themselves at risk for increased mental instability. Those lacking access to treatment may resort to harmful suppression techniques, such as alcoholism, poor eating habits, procrastination, and isolation.

Even with better access to care and heightened public awareness in the United States, there remains potential for improvement in mental health services. I believe this

¹³ Queensland Brain Institute, “Half of World’s Population Will Experience a Mental Health Disorder,” News and Research, Harvard Medical School, July 21, 2023, <https://hms.harvard.edu/news/half-worlds-population-will-experience-mental-health-disorder>.

¹⁴ John Gramlich, “Mental Health and the Pandemic: What U.S. Surveys Have Found,” Short Reads, Pew Research Center, March 2, 2023, <https://www.pewresearch.org/short-reads/2023/03/02/mental-health-and-the-pandemic-what-u-s-surveys-have-found/>.

¹⁵ “Women and Mental Health,” Explore Mental Health, Mental Health Foundation, Last modified October 12, 2021, <https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/women-and-mental-health>.

¹⁶ Colleen L. Barry, Haiden A. Huskamp, and Howard H. Goldman, “A Political History of Federal Mental Health and Addiction Insurance Parity,” *The Milbank Quarterly* 88, no. 3 (September 2010): 404-33, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754/>.

presents an opportunity for the church. I envision ministry leaders seriously considering the effects of mental health and compassionately coming alongside those who are struggling, demonstrating empathy and care. I have designed this project to investigate whether training on trauma and mental distress can equip ministry leaders to extend greater compassion, empathy, and care toward those members who are suffering mental distress.

Research suggests that ministry leaders are positioned to help those struggling with mental health. Psychiatry.org reports, “People experiencing mental health concerns often turn first to a faith leader.”¹⁷ Additionally, a Harvard study found that “People who attended religious services at least once a week were significantly less likely to die from ‘deaths of despair,’ including deaths related to suicide, drug overdose, and alcohol poisoning.”¹⁸ Interestingly, this study suggested the benefit was more significant for women than men.¹⁹

Medically trained personnel are vital for those suffering from mental illness. Yet, when addressing mental health, faith-based organizations can provide a place of acceptance, compassion, love, and guidance. They can lead the effort to dispel myths surrounding mental health. Offering belief in something higher can serve as a bridge to healing. Pastoral counseling services, which many faith communities already offer, “can

¹⁷ American Psychiatric Association Foundation, *Mental Health: A Guide for Faith Leaders* (Arlington, VA: American Psychiatric Association Foundation, 2016).

¹⁸ Chris Sweeney, “Regularly Attending Religious Services Associate with Lower Risk of Deaths of Despair,” News, Harvard T.H. Chan School of Public Health, May 6, 2020, <https://www.hsph.harvard.edu/news/press-releases/regularly-attending-religious-services-associated-with-lower-risk-of-deaths-of-despair/>.

¹⁹ Sweeney, “Regularly Attending.”

be an additional support to therapy and may help people cope with mental health challenges.”²⁰ Church, where people worship, is where conversation about mental health can begin.

Those suffering from mental health challenges should be seen, understood, and heard without judgment. While not a substitute for medical intervention, pastoral counseling and church leaders can support those suffering through biblical truths, guidance, sympathy, listening, and compassion. In these conversations, congregants can safely share the deeply buried hurts underlying their mental unwellness. Mental and physical abuse leave emotional scars that often echo in the victim's mind, causing a loss of self and contributing to poor mental health.²¹ Women and men from varied religious denominations desire to release themselves of the long-held secrets affecting their well-being.²² Such vulnerable sharing “has been a source of relief for centuries.”²³ Emotional relief can begin with being able to say, “This has bothered me for years,” “I thought it was my fault,” “I didn’t know if God would forgive me,” “There was no one who would listen to me,” or “my family knew something was going on and didn’t say anything.”

²⁰ Sweeny “Regularly Attending.”

²¹ Jenna Fletcher and Beth Sissons, “What are the Effects of Emotional Abuse?” *Medical News Today*, last modified September 4, 2024, <https://www.medicalnewstoday.com/articles/327080>.

²² Patrick W. Corrigan and Deepa Rao, “On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change,” *Canadian Journal of Psychiatry* 57, no. 8 (August 2012): 464. <https://doi.org/10.1177/070674371205700804>.

²³ Diane E. Dreher, “Why Talking About Our Problems Makes Us Feel Better,” *Your Personal Renaissance* (blog), *Psychology Today*, June 11, 2019, <https://www.psychologytoday.com/us/blog/your-personal-renaissance/201906/why-talking-about-our-problems-makes-us-feel-better>.

Context

Jubilee Community Church (JCC) was founded on January 6, 1996, by Pastor Palmer Jason, who was given a vision of opening a church in the South Dayton, Ohio area. Located in Montgomery and Warren Counties, Jubilee ministers to people in the cities of Dayton, Springboro, Miamisburg, Centerville, Franklin, Kettering, Oakwood, Huber Heights, Waynesville, West Carrollton, West Chester, Lebanon, and Cincinnati. JCC exists to carry out the great commission and the great commandment by a people set free to serve.

Jubilee Community Church comprises men, women, and children of diverse ethnicities. Congregants are physicians, lawyers, educators, business entrepreneurs, firefighters, military, police officers, corporate executives, clinical specialists, retired professors, in-home healthcare providers, nurses, accountants, childcare workers, personal trainers, bookkeepers, and administrators. Through preaching and teaching, members learn a message of faith and about a God who loves and cares about them.

In July 2023, the United States Census of Montgomery County reported an estimated population of 533,796, with 51.6% women; the largest racial/ethnic group in Montgomery County, White at 71.7%, Black/African American, 22%; American Indian and Alaska Native at 0.3%, Asian, 2.5%; Native Hawaiian and Other Pacific Islander 0.1%, Two or More Races, 3.3%, Hispanic or Latino 4.3%, White alone, not Hispanic or Latino 68.3%. The poverty level as of July 2023 is listed at 14.3%.²⁴

As of July 2023, Warren County has an estimated population of 252,148, with 49.6% listed as women; the racial/ethnic groups include White (86%), Black/African

²⁴ Census Bureau, <https://www.census.gov>.

American (3.9%), American Indian and Alaska Native 0.2%, Asian (7.5%), Native Hawaiian and Other Pacific Islander alone, 0.2%, Two or More races present 2.2%, Hispanic or Latino, 3.6%, White alone, not Hispanic 82.9%. Their poverty level as of July 2023 was 5.5%. In 2020, the poverty level in Warren County was 6.2% (or 15,025 people), and it was reported during that time that mental health concerns were on the rise.²⁵

JCC serves an area of Ohio that has experienced significant economic pressure during the last two decades. Data from the federal government in 2011 indicates Montgomery County, Ohio, lost 200 businesses within ten years. Already facing economic pressure, the state experienced additional stress during the pandemic. Mike Dewine, Governor of Ohio, announced that since March 2020, 17,500 Ohioans have died from pandemic-related issues. In May 2020, Montgomery County received 92 million dollars to support the local economy and community through the CARES (Coronavirus Aid, Relief, and Economic Security) Act. This funding was intended to support the health and wellness of Ohio residents: “Montgomery County has allocated \$10M from federal CARES Act funds to aid healthcare institutions. These grants are meant to help Montgomery County hospitals, medical centers, health clinics, and other health service providers that incurred or anticipate additional expenses related to the pandemic.”²⁶ One dimension of the CARES Act provided individuals experiencing imminent eviction with

²⁵ Census Bureau.

²⁶ “Montgomery County Rolls Out CARES Act Grants for Healthcare Institutions, Daycares and Preschools, and Agricultural Businesses,” Montgomery County Community and Economic Development, September 21, 2020, <https://www.selectmcohio.com/news-and-events/p/item/29669/montgomery-county-rolls-out-cares-act-grants-for-healthcare-institutions-daycares-and-preschools-and-agricultural-businesses>.

additional time before being required to vacate the premises.²⁷ Today, these critical revenue sources face the threat of elimination, creating financial hardship for families and potentially impacting psychological health.

“During August 2020–February 2021, the percentage of adults with recent symptoms of an anxiety or a depressive disorder increased from 36.4% to 41.5%, and the percentage of those reporting an unmet mental health care need increased from 9.2% to 11.7%.”²⁸ These increases are concerning and suggest a need for a solution. “History has shown that the mental health impact of disasters outlasts the physical impact, suggesting today’s elevated mental health needs will continue well beyond the coronavirus outbreak itself.”²⁹

Mental health is a nationwide problem, and while there is no one solution JCC has the opportunity to serve those suffering from mental health within their community. Understanding mental health can lead to more people seeking help; I believe JCC can promote mental well-being by educating congregants about mental health and providing resources and companionship in a safe, non-judgmental way. This can aid in removing the stigma and guide those impacted to the help/treatment needed. This is an invaluable way to bring hope and does not replace the need for the care of professionally trained medical staff. It is simply a tangible way to accompany individuals who feel isolated and

²⁷ “Cares Act,” National Low Income Housing Coalition, <https://nlihc.org/cares-act>.

²⁸ Angel Vahratian, Stephen J. Blumberg, Emily P. Terlizzi, and Jeannine S. Schiller, “Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care among Adults During the COVID-19 Pandemic – United States, August 2020–February 2021,” *Morbidity and Mortality Weekly Report* 70, no. 13 (April 2, 2021): 490–4, <http://dx.doi.org/10.15585/mmwr.mm7013e2>.

²⁹ Nirmita Panchal, Rabah Kamal, Cynthia Cox, and Rachel Garfield, “The Implications of COVID-19 for Mental Health and Substance Use,” Mental Health, KFF, February 10, 2021 <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

may be struggling with their mental health. Because JCC is not tied to any specific governing body, it has the opportunity and the ability to implement programs without needing hierarchical approvals.

Census data highlights the rise in mental health concerns and underscores the importance of addressing and guiding those who are suffering. The worldwide pandemic stretching from late 2019 through early 2023 elevated public awareness of issues involving psychological, emotional, and social well-being functions specific to mental health (not to be confused with mental illness).³⁰ Pandemic safety measures, including “shelter-in-place” (SIP), caused isolation, which negatively affected mental health and led to more people experiencing mental health issues. Although recent events have worsened this trend, data show that mental health problems, especially anxiety and distress, are common worldwide. Many individuals have suffered privately, and some groups face greater challenges than others.

Understanding how mental health is perceived across various racial and ethnic groups is essential. Cultural differences and limited knowledge about mental health often prevent many individuals from seeking the support they need. Stigma greatly influences whether people decide to seek help. For some communities, acknowledging mental health issues can bring shame and guilt, which causes people to avoid discussing or seeking assistance when they are in distress. African Americans are a group known to have less trust in mental health care. Although JCC is a diverse congregation, most of its members are of African American descent (Black).

³⁰ “About Mental Health,” Mental Health, Centers for Disease Control, <https://www.cdc.gov/mentalhealth/learn/index.htm>.

Among those of African American descent, values such as privacy and the importance of not sharing what happens at home can prevent individuals from realizing that help is available and that their experiences are not isolated, and they don't have to suffer in silence. Unfortunately, racism has played a significant role in causing this community to adopt such views. “Just as we see in other areas of medicine, people of color suffer mental health consequences to a greater degree than White Americans. Not only are people of color limited in their access to effective mental health care, but they are also subject to discrimination and social disadvantage that can be invisible to White individuals, making existing problems worse.”³¹

Black people have historically faced prejudice and discrimination in the US healthcare system. Unfortunately, many still encounter these negative experiences when seeking care.³² Additionally, it is noted that Black individuals are less likely to receive consistent care; they are rarely included in research, and when experiencing mental health symptoms, they are more likely to go to emergency rooms rather than seek mental health counseling from a trained professional. They might not realize that others could also go through moments of distress caused by similar experiences. “The Black community, like other communities of color, is more likely to experience socio-economic disparities such as exclusion from health, educational, social, and economic resources. These disparities

³¹ Monnica T. Williams, “People of Color and Mental Health Care: The Double Bind,” *Culturally Speaking* (blog), *Psychology Today*, June 30, 2021, <https://www.psychologytoday.com/us/blog/culturally-speaking/202107/people-color-and-mental-health-care-the-double-bind>.

³² National Alliance on Mental Illness (NAMI), “Black/African Americans,” Identity and Cultural Dimensions, accessed September 8, 2025, <https://www.nami.org/your-journey/identity-and-cultural-dimensions/black-african-american>.

may contribute to worse mental health outcomes.”³³ This lack of equality among groups fosters stigma and, as a result, decreases some groups' willingness to ask for help and seek support.

“The National Alliance on Mental Illness determined that ‘misdiagnoses, inadequate treatment, and lack of cultural competence by health professionals cause distrust and prevent many African Americans from seeking or staying in treatment.”³⁴ These are not the only obstacles to seeking and receiving treatment. “One psychologist reported that many of her African American clients avoided psychotherapy due to fear of judgment. A client stated, “Getting this type of help has, and continues to be, like a sore thumb in the African American community.” In many communities of color, visiting a counselor implies that the family has failed to resolve problems internally, and disclosures may add fuel to existing negative stereotypes.”³⁵

Other groups with negative views of mental health include those of Hispanic and Asian ancestry, which create barriers to receiving help with their mental health.³⁶ “Black, Hispanic, AIAN, and Asian adults report higher levels of unfair treatment when seeking health care than their White counterparts. Adults who say they were treated unfairly or with disrespect by a health care provider are more likely to report not getting mental health services they thought they needed compared to those who do not report unfair

³³ NAMI, “Black/African Americans.”

³⁴ NAMI, “Black/African Americans.”

³⁵ Williams, “People of Color and Mental Health Care.”

³⁶ Samantha Artiga et al, “Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial Groups,” Racial Equity and Health Policy, KFF, December 5, 2023, <https://www.kff.org/racial-equity-and-health-policy/survey-on-racism-discrimination-and-health/>.

treatment (41% vs. 18%), and this difference persists among those with self-reported fair or poor mental health status (67% vs. 40%).”³⁷

The church has served as a haven of hope for the Black community, especially during times of distress. “While history provides a clear picture as to why African Americans choose the Black church for emotional support, it is important to acknowledge the cultural barriers that make mental health agencies a least favorable option.”³⁸ Many factors contribute to the stigma Black churches have against mental health, including ongoing mistreatment and institutional barriers that hinder their success. People who seek help from trained therapists are often seen as “crazy” or “emotionally weak,” or as having spiritual flaws. These are just some of the reasons why many avoid pursuing mental health support treatment.³⁹

Addressing mental health within the church is not a new role for it to assume. In the past, people turned to the church for relief, hope, and spiritual nourishment. The Bible acknowledges that people are multidimensional, discussing body (1 Thess. 5:23), mind (Rom. 12:2), and spirit/soul (Psalm 23:3). The soul is where our emotions reside, along with the intellectual energy that facilitates feeling and inspiration. When a person’s spirit is sick, their soul suffers; when it is healthy, it allows them to think more clearly. A person’s spirit influences their mind, behavior, life, and thinking. The church can offer hope and a foundation. Church is a place where individuals can experience acceptance,

³⁷ Artiga et al, “Survey on Racism, Discrimination and Health.”

³⁸ Keith Dempsey, S. Kent Butler, and LaTrece Gaither, “Black Churches and Mental Health Professionals: Can This Collaboration Work?” *Journal of Black Studies* 47, no. 1 (2016): 75. <http://www.jstor.org/stable/24572960>.

³⁹ Dempsey, Butler, and Gaither, “Black Churches and Mental Health Professionals,” 75.

which leads to healing, as we are mind and body, functioning in wholeness as God intended. The Bible affirms the church's role in healing body, mind, and spirit. James 5:14-25 directs, “Is anyone among you sick? Let them call the church elders to pray over them and anoint them with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise them up. If they have sinned, they will be forgiven.” Still, providing strong support for mental health requires intentionality.

The church's role is not to overwhelm the hurting with scripture but to guide them with it. Since mental health is a complex issue, addressing its core requires a safe and trusting environment. In a busy world, the church can serve as a retreat from a time when there was no multi-channel cable, social media, streaming channels, or isolation—when people came together and shared life experiences. Faith-based organizations help individuals momentarily forget their problems and be spiritually nourished. Jubilee Community Church (JCC) has implemented Bible studies and programs that support congregants' spiritual health, which benefits their overall well-being. However, these tools are limited. Additional resources are available for churches seeking to address mental health, and discovering and adopting them requires research and training.

Many tools and resources are geared toward self-help. The National Institute of Mental Health offers several suggestions for enhancing your mental well-being, including regular exercise, engaging in relaxing activities, ensuring adequate sleep, setting goals, practicing gratitude, and maintaining a healthy diet.⁴⁰ However, these strategies fail if one lacks the motivation to stick with it or needs proper guidance. Having a faith-based

⁴⁰ “Caring for Your Mental Health,” Health Topics, National Institute of Mental Health, <https://www.nimh.nih.gov/health/topics/caring-for-your-mental-health>.

community to encourage you can stimulate and strengthen your motivation to pursue healing. The church can provide community support and highlight the benefits of coming together to worship, offering hope, social events for a sense of community, and leaders who are there to listen and help during crises.

Recently, I formed a focus group of ten women from various backgrounds and ages to identify those seeking to manage stress-related problems. The goal was to determine how comfortable a group of women who may not know each other would be discussing issues related to distress. Their locations included Montgomery and Warren counties, and a few women who resided out of state participated via Zoom. As the facilitator, I found that once the group understood the purpose of the focus group and established guidelines, most importantly the need for confidentiality, they quickly began to open up the discussion. Ultimately, these women felt comfortable talking openly with one another about horrific life events. Afterward, when I asked why they felt comfortable, they responded that they were provided a safe space. This safe space, created by the church, allowed them to share their stories and begin to accept what they had experienced and were experiencing, knowing they were not alone.

These women listened to each other, offered encouragement, and demonstrated compassionate care and empathy for each other's suffering. Each conveyed sincere care and compassion and was willing to listen, letting each other know they were not alone. Dr. Robyn Fivush states, "Listening to other's stories is a lifelong process of understanding yourself and others. Perhaps especially at this turbulent time, sharing our stories helps us process and understand our experiences in new ways and build new

connections.”³¹ Critically for mental health, “Closely listening to others’ stories creates a shared moment of compassion.”⁴¹

Ministry Journey

As a pastor and ministry leader, I have witnessed firsthand the effects mental health can have on a person. I am the assistant pastor of JCC and the founder and president of Mamie Johnson Ministries, a faith-based 501(c)(3) initiative. I serve on the board for the Greater Dayton Emmaus Community as a Spiritual Director and have authored several personal books, including two devotionals and three others that directly and indirectly address situations I have experienced related to mental health. I present seminars and workshops, preach, teach Bible study, and conduct spiritual and marriage counseling for congregants facing life challenges. I speak at different churches for special events and write and publish material to help others seek peace through Christ.

Sitting with congregants one-on-one and in groups has shown me the need and desire to develop a mental health program in the church. Specifically, I see a need for programs that alleviate apprehensions around mental health due to stigma, judgment, or lack of knowledge. People have many concerns about mental health, and the answers are uncertain, but having a safe space to talk provides more opportunities for guidance for those who are suffering. Being vulnerable with congregants and allowing a window into my struggles has enabled others to share their concerns. As Dr. Brené Brown explains,

⁴¹ Robyn Fivush, “Listening to Stories: The Power of Story Circles,” *The Stories of Our Lives* (blog), Psychology Today, August 13, 2020, <https://www.psychologytoday.com/us/blog/the-stories-our-lives/202008/listening-stories-the-power-story-circles>.

“Vulnerability is the birthplace of love, belonging, joy, courage, empathy, and creativity.”⁴²

Engaging with congregants, discussing issues, and acknowledging their suffering demonstrates that they are not alone. An inability to express feelings and concern can be isolating. The Centers for Disease Control and Prevention (CDC) defines social isolation as “when a person does not have relationships or contact with others and has little to no social support.”⁴³ Those who suffer in silence experience a form of grief that inhibits emotional and spiritual development into the person God designed them to be. When someone shares similar circumstances they have faced, it can open the door to understanding and lead to healing. Faith-based organizations can provide a space for dialogue, show compassion, and listen, especially when individuals are experiencing loneliness and anxiety.

In the context of mental health work within the church, formal education is essential, while biblical training and spiritual discernment are vital for catalyzing healing. God is the one who grants gifts and has revealed hidden things that have bound the afflicted, handcuffing them and making them prisoners of their thoughts. The church needs Doctors of Ministry who seek knowledge from well-trained individuals whose doctrinal writings have been thoughtfully researched and who are committed to the wholeness that comes from God. Individuals who deepen their understanding of God’s word and cultivate application-oriented skills through well-researched information will

⁴² “Daring to be Vulnerable with Brené Brown,” Taking Charge of Your Wellbeing, University of Minnesota, <https://www.takingcharge.csh.umn.edu/daring-be-vulnerable-brene-brown>.

⁴³ “Health Effects of Social Isolation and Loneliness,” Social Connection, Centers for Disease Control, last modified March 26, 2024, <https://www.cdc.gov/social-connectedness/risk-factors/index.html>.

play a role in influencing and relieving those in distress. As a pastor with formal education and a credentialed understanding of biblical teaching and truths, I believe Jesus calls His followers to engage in ecclesial Christian action toward everyone.

Develop the Synergy

I intend to explore the causes of mental health, the effects of mental health on individuals and communities, and how the church can support those struggling with mental health. This exploration seeks to acknowledge, address, and hopefully reduce some mental health stigma to promote conversation, provide guidance, and encourage hope. I designed this project to develop strategies and tools for JCC to use as it supports those grappling with mental health.

The project will seek six to ten volunteers, 21 years or older, women or men (ministry leaders) within JCC, to participate in a six-week overview of mental health. A synopsis of mental health will be provided, covering the Biblical, Historical, Theological, and Interdisciplinary aspects. There will then be discussion time to hear their views, and journals will be distributed to take home along with prompting questions to consider before the next meeting. I will also conduct one-on-one interviews with participants to gather views that they may not feel comfortable sharing in a group environment.

Journals will be collected at the end of the six weeks, and an open discussion will determine the next steps, including whether the church should participate and if the participants would be willing to take a training class on how to identify signs of distress.

Resource tools related to mental health have been identified for organizations, along with tips on how leadership can integrate them into existing programs within their

churches.⁴⁴ Although there is a cost associated with training, the benefits could outweigh the costs. My project seeks to inform and determine whether ministry leaders are willing to take on this role as facilitators. If so, the next phase would be implementing the training.⁴⁵

I will seek ministry leaders interested in this subject via personal email, one-on-one meetings, or phone calls. They will then participate in a six-week, one-day-a-week overview on mental health and will be given pre- and post-interviews and journals to record their thoughts and facilitate open discussions. Once the six-week training is complete, an open forum will follow, and a survey will be distributed among participants to determine the effectiveness of the information provided and the comfort of leadership in utilizing what they have learned and choosing the next steps. In “Studying Congregations,” “A person does not need to be a psychiatrist to reflect on their emotional states . . . What is required, however, is to follow a discipline of investigation, an ordered system of examination and exercises that can lead to insight and self-understanding.”⁴⁶

Through this project, I aim to discover whether ministry leaders can learn to identify signs of distress and how many are open to seeking faith-based mental health guidance. If successful, this program strategy has the potential to be implemented universally across denominations.

⁴⁴ Jeremy Smith, “Spiritual First Aid Training,” Pastors, Church and Mental Health, last modified July 27, 2023, <https://churchandmentalhealth.com/spiritual-first-aid/>.

⁴⁵ Smith, “Spiritual First Aid Training.”

⁴⁶ Nancy Tatom Ammerman, Jackson W. Carroll, Carl S. Dudley, and William McKinney, *Studying Congregations: A New Handbook* (Nashville, TN: Abingdon Press, 1998), 197.

CHAPTER TWO

BIBLICAL FOUNDATIONS

Introduction

Jesus often taught His followers through enigmatic stories, known today as parables. This ancient teaching technique challenged His listeners to find a deeper meaning behind the straightforward narrative. Although Jesus' parables frequently addressed the circumstances of His time, they may still be relevant in today's society. Parables are powerful, and pastors and teachers have used them to preach bold and convicting messages. Jesus' teachings will not always leave us comfortable. They should challenge and cause the hearer to see the obvious, even if uncomfortable. Scholars like Crossan argue, "It is a cliché in parable analysis that such stories must be true to life, either to the recurrent actualities or the recognizable possibilities of experience and existence."¹ Yet, there are cases where these stories resemble current-day situations.

As Jesus taught, his objective was to broaden and enlighten His listeners, not to condemn them. Many parables in the Jesus tradition or logia are considered polyvalent, or having many meanings.² Some believe Jesus' parables are atypical, leaving each

¹ Norman A. Huffman, "Atypical Features in the Parables of Jesus," *Journal of Biblical Literature* 97, no. 2 (1978): 207.

² Stephen J. Patterson, "Everything in Parables: On Jesus' Style," in *The Message of Jesus: John Dominic Crossan and Ben Witherington III in Dialogue*, ed. by Robert B. Stewart (Minneapolis, MN: 1517 Media, 2013), 117-26.

listener or reader to conclude their meaning. In his book “Everything in Parables,” Stephen Patterson contends that many scholars believe parables were originally all open-ended in spite of the fact that gospel writers often resolve them into a moral or lesson to be learned.³ When hearing parables, people want to hear a story that can be believed.”⁴

“The hearer or reader of a parable expects a story that is believable. Dodd stated this emphatically in reference to Jesus’ parables:

... all is true to nature and to life. Each...story is a perfect picture of something that can be observed in the world of our experience.... [The] actions of persons in the stories are...either such as anyone would recognize as natural in the circumstances, or, if they are surprising, the point of the parable is that such actions are surprising.⁵

Usually short, parables offer an opportunity to consider more than one theme. Readers often focus on what appears evident in parables. Yet, one must consider that each parable contains more than what is on the surface. Jesus’ teachings are not easily understood, as was intentional. As Jesus explained to his disciples,

The secret of the kingdom of God has been given to you. But to those on the outside everything is said in parables so that, ‘they may be ever seeing but never perceiving, and ever hearing but never understanding; otherwise, they might turn and be forgiven!’ (Mark 4:10–12)⁶

This passage indicates not everyone has the ability to interpret His teaching.

Although parables are not easily understood, they should not be dismissed as fictional stories that lack an applicable message today since “The main concern of Jesus

³ Patterson, “Everything in Parables.” 118.

⁴ C.H. Dodd, *The Parables of the Kingdom* (New York, NY: Scribner, 1961), 9.

⁵ Huffman, “Atypical Features,” 207.

⁶ All Bible verses taken from the New International Version of the Bible.

in his parables was the essential character of the kingdom and its absolute demands.”⁷

This is the essence of the parable of the Samaritan (Luke 10:25–37), examined in this paper, which illustrates the connection between Christian action and character. Based on the parable of the Samaritan, I will provide an overview of the theme as it applies to the importance of caring for those in need, specifically how those experiencing distress can find a safe place within the church for empathy, compassion, encouragement, and guidance. This paper seeks to extract meaning from the parable that can guide Christian action and illustrate that the church is a community—a gathering place where people can come together to find relief, rest, and support, whether a member or a stranger. It is a place where you find people eager to serve others with whatever gifts they may have, whether monetary or through acts of service and this assistance includes everyone without discrimination. I hypothesize that “If ministry leaders are trained to recognize the signs of distress (i.e., anxiety and depression), then they will be better equipped to exercise compassion and guide congregants to the help they need.”

While we acknowledge that church attendance is voluntary and can be described as a community of individuals with similar beliefs socializing together for worship, the church is more than that. The church has the responsibility to call sinners to repentance. However, urging someone to repent while they are suffering and in despair makes repentance feel like a less significant priority. Where one attends church depends on personal preferences, including polity, music, building, programs, other attendees, and more. Church is a place where individuals' needs and welfare can be addressed, tensions

⁷ Everett Ferguson, *The Everlasting Kingdom: The Kingdom of God in Scripture and in Our Lives* (Abilene, TX: ACU Press, 1989), 2.

eased, anxieties calmed, and worries set aside for just a few moments as pastors and leaders provide words of comfort, encouragement, and hope. As scripture is shared, those attending receive guidance and moral direction. The church provides, even if just for a moment, a chance for people to set aside their worries, find hope and relief, and rid themselves of unspoken internal suffering and distress. This paper will contextually exegete the scripture found in Luke chapter ten, the story of the Samaritan, and offer a perspective on why and how it fits in with today's climate, specifically in addressing those experiencing distress. Additionally, I will explore themes of the righteousness of God, love, compassion, who is our neighbor, prejudice, and altruism.

Exegesis

On one occasion, a law expert stood up to test Jesus. "Teacher," he asked, "what must I do to inherit eternal life?"

"What is written in the Law?" he replied. "How do you read it?"

He answered, "'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'; and, 'Love your neighbor as yourself.'"

"You have answered correctly," Jesus replied. "Do this and you will live."

But he wanted to justify himself, so he asked Jesus, "And who is my neighbor?"

In reply Jesus said: "A man was going down from Jerusalem to Jericho, when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he traveled, came where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him. The next day he took out two denarii and gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have.'"

"Which of these three do you think was a neighbor to the man who fell into the hands of robbers?" The expert in the law replied, "The one who had mercy on him." (Luke 10:25–37)

“At its simplest the parable is a metaphor or simile drawn from nature or common life, arresting the hearer by its vividness or strangeness, and leaving the mind in sufficient doubt about its precise application to tease it into active thought.”⁸ Typically, a parable conveys a moral lesson of one's responsibility towards another. While fictitious, parables “never indulge in the fanciful or fantastic, but remain true-to-life.”⁹ Parables are often told simplistically, provoking the listener to ask a question to grasp its meaning. Jesus’ parables are rooted in the Jewish tradition. According to André LaCocque, A parable is, in Hebrew terms, a *haggadic*, a Jewish text that indicates the order of service, or midrashic *mashal*, a form of storytelling in the form of Jewish interpretation. The whole of the Jewish tradition is bidimensional; it is built into the *halakah* (legal dispositions) and the *Haggadah* (paradigmatic stories illustrating the meaning, impact, and relevance of a biblical theme or text).¹⁰

In the tenth chapter of the Gospel of Luke, Jesus had just appointed seventy-two to go ahead of Him to every town to preach the Good News (Luke 10:1). As He is on His way to Jerusalem, He encounters a legal expert. The legal expert questions Jesus regarding eternal life. “What must I do to inherit eternal life (Luke 10:25b)?” followed by another question, “What is written in the law (Luke 10:26a)?” Scripture indicates that the law expert stood up, which begs the question: had Jesus been teaching prior to sending out the seventy-two, and was the law expert seeking to know the answer to his question

⁸ Dodd, *The Parables of the Kingdom*, 16.

⁹ Madeleine I. Boucher, “Jesus’ Many Faces – The Parables,” From Jesus to Christ, Frontline, <https://www.pbs.org/wgbh/pages/frontline/shows/religion/jesus/parables.html>.

¹⁰ André LaCocque, “Jesus Taught in Parables,” in *Jesus the Central Jew: His Times and His People*, ed. by Gail R. O’Day (Atlanta, GA: SBL Press, 2015), 169.

or to invalidate that Jesus was the Son of God? One could conclude that the law expert was a Pharisee because of their strict adherence to the law (Matthew 23:23). The Pharisees did not understand the weightier matters of the law, like matters of judgment, mercy, and faith (Matt. 23:23).

To understand the parable of the Samaritan, it is essential to consider the cultural and historical backgrounds of the Jews and the Samaritans. Samaritans were marginalized and considered not entirely pure due to intermarriage (Ezra 9:10, 44; Neh. 13:23-28). They lacked many advantages that the Jews of pure ancestry had. Historically, there was animosity between the two groups. The Jews were seen as God's chosen people, set apart to worship Him and lead holy lives, exemplifying God's love for all. In contrast, the Samaritans were a mixed race who did not adhere to Jewish teachings and did not recognize the temple in Jerusalem as a sacred place of worship, leading them to build their temple on Mount Gerizim (Ezra 4).

Rooted in Old Testament teachings, Jews regarded Samaritan religious practices as morally wrong and viewed them as renegades (Ezra 4). Likewise, the Samaritans harbored animosity toward Jews (Ezra 4). Various factors contributed to the negative perceptions of the two groups. The Jews viewed the Samaritans as impure, lacking complete Jewish ancestry, which resulted in their status as outcasts. Rejection based on nationality is not a new phenomenon. America has struggled with the roots of racism, particularly in the treatment of non-white citizens. Laws restricted interracial interactions, access to public transportation, participation in recreational facilities, military service, and school attendance. Rejection based on nationality is just one example of how groups cultivate negative views of those different from themselves.

Other factors to consider when interpreting the setting of this parable include the location of the event. Travelers along this road faced difficult conditions. The road from Jerusalem to Jericho was perilous due to the incidents that occurred for those who chose this route. An excerpt published by The University of Chicago Press on behalf of The American Schools of Oriental Research and written by John Wilkinson states, “because of the blood which is often shed there by robbers...It is on the way down from Aelia (i.e. Jerusalem) to Jericho, and there is also a soldiers’ castle located there to provide help for travellers.” Jerome’s preference for this interpretation becomes obvious when he says, “the Lord also reminds us of this bloody, bloodthirsty place in the parable of the man who went down from Jerusalem to Jericho.”¹¹

The road from Jerusalem to Jericho was a rugged landscape, making it easy for robbers to hide and for unsuspecting travelers to fall victim. “In Christianity, the term rough road symbolizes the challenging and difficult journey one must undertake for spiritual growth and maturity. It serves as a metaphor for the various tough experiences and obstacles faced in life. This imagery reflects the notion that such trials are integral to personal development and faith, portraying the arduous path that individuals encounter throughout their lives. Ultimately, the rough road represents the struggles that contribute to one's spiritual journey.”¹² Jesus seeks to challenge and broaden the law experts' understanding of the law, especially regarding the concept of “neighbor.” He urges them

¹¹ John Wilkinson, “The Way from Jerusalem to Jericho,” *The Biblical Archaeologist* 38, no. 1 (1975): 19.

¹² Gabe Hiemstra, “The Concept of Rough Road in Christianity,” Wisdom Library, last modified April 13, 2025, <https://www.wisdomlib.org/christianity/concept/rough-road>.

to see everyone as their neighbor and recognize that love, compassion, and kindness is universal and should be extended to everyone.

The legal expert was not seeking information about inheriting eternal life; he already knew the answer. Rather than directly answering his question, Jesus posed a different question. Jesus masterfully engages the legal expert using the Socratic method,

Historically, the Socratic method, found in the Platonic Dialogues, dates back more than 2,500 years. In these dialogues, the historical Socrates engages participants by going through several conversational stages. The stages Socrates uses are (a) Wonder, (b) Hypothesis, (c) Elenchus (refutation and cross-examination), (d) Accept/reject the hypothesis, and (e) Act accordingly (Dye, 1996).¹³

Jesus asked several questions, “What is written in the law? How do you read it?” (Luke 10:26). The expert referenced the Mosaic Law, “‘Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind’ and, ‘Love your neighbor as yourself’” (Luke 10:27).

Parables can have several meanings, yet they maintain their original intent to enhance understanding and broaden the truth. The command to love God reflects His righteousness and demonstrates that He is the one we look to for guidance on what is morally right and wrong. This is exemplified by what Jesus did on the cross as the sacrifice for humanity's sins. Jesus made us right with God. Loving God means seeking Him with your whole being—your existence, soul, mind, strength, and everything you are (Luke 10:27). However, that is not the only way to love God. We must also “love your neighbor as yourself” (Luke 10:27b). In addition to loving God, believers are called to be

¹³ Peter Boghossian, “Socratic Pedagogy, Critical Thinking, and Inmate Education,” *Journal of Correctional Education* 57, no. 1 (2006): 44.

altruistic. While loving God is essential, failing to show that love to others indicates a lack of true devotion to Him.

An important aspect to consider is the true definition of love according to God's word. Love is often underestimated. However, the type of love that Jesus teaches involves one's entire being. Loving oneself is essential to loving others.

Jesus skillfully encouraged the law expert to reflect on how he might demonstrate this kind of love and prompted him to consider whether his actions truly emulated God's law. A key word in Luke 10:27b is "and." Jesus connects loving God with loving others. The two are joined in mutuality, representing the essence of God's law. Loving God fulfills His law, but loving others—your neighbor—is equally important. If you do not love your neighbor, you do not truly love God. So then, who is our neighbor? Jesus aimed to give the lawyer a comprehensive understanding of the law's meaning, not just its wording. He wanted to understand how the lawyer interpreted and practically applied its meaning.

According to the law, the lawyer's response was correct. Jesus responds, "Do this and you will live" (Luke 10:28). However, the lawyer continued. He wanted more; he could be perceived not as seeking understanding but as challenging Jesus' understanding of neighbor. Thus, the questioning continued: "And who is my neighbor?" (Luke 10:29b). The term neighbor is often understood to mean someone who is nearby, someone who is in close proximity to another. In his article "Who Is My Neighbor?", Jeremy Waldron presents a list of questions and considerations to comprehend who a neighbor is. He asks:

What is the scope of morality? To whom are we obligated? Who are we morally required to help? Whom may we not harm? Whom commands our respect and

from whom are we forbidden to withhold our assistance? Do moral concerns and requirements diminish over distance so that our duties are stronger to those who are near to us and weaken to vanishing point as possible beneficiaries of our actions and inactions are found further and further away? And what does “distance” mean in these circumstances? When is a person near to me? When is a person far away? Is it a matter of who they are, and of their relation to me (affection, blood, fellow-citizenship)? Or is it sheer geography? If it is geography, does a person count as near or far in virtue of where they live or in virtue of where (right now) they happen to be?¹⁴

Jesus gave this parable in response to the persistent inquiry of the law expert, and only after recounting it did He ask the law expert another question. “Which of these three do you think was a neighbor to the man who fell into the hands of robbers?” (Luke 10:36). He replied, “The one who had mercy on him” (Luke 10:37b). Jesus instructed the expert to “go and do likewise” (Luke 10:37b). The insight gained from the parable aimed to deepen his understanding of not only the law but also how true love, godly love, is demonstrated.

Prejudices divide us. Those who saw the injured man and ignored him exhibited just that: forming opinions based on physical observation. While they may have had reasons related to their priestly roles (the Priest and the Levite’s need to remain ritually and ceremonially clean), the Priest and the Levite were traveling away from Jerusalem, away from the central place of worship. They had already performed their duties at the temple. However, physical observation should have prompted the injured man to receive assistance:

A man was going down from Jerusalem to Jericho when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side (Luke 10:30a-32).

¹⁴ Jeremy Waldron, “Who is My Neighbor?: Humanity and Proximity,” *The Monist* 86, no. 3 (2003): 333–54.

It was evident that the man was injured. The robbers stripped him of his clothes, beat him, and left him on the road—hurt, alone, distressed, and in need of someone willing to show empathy and compassion. The Priest traveling the same road saw the man. Instead of helping him, the Priest crossed to the other side, choosing not to offer aid, investigate what had happened, or consider how he could help. During that time in Jewish history, Priests were responsible for studying and proclaiming the word of God. They acted as intercessors before God on behalf of the people, performed sacred rituals, and were regarded as holy figures. Was the Priest appalled by the man's appearance, prompting him to cross the street? Or was he so immersed in his vital religious role that he felt no obligation to engage in seemingly trivial matters? Such attitudes can be observed in those in priestly roles today who choose only to fulfill their duties without considering the conditions of the people they serve.

Another man, a Levite, also saw the injured man but chose to avoid him. Levites were part of the priestly line but held different responsibilities. In this parable, the Levite illustrates how hierarchy can shape the understanding of individual responsibility. Why was he hesitant to offer help? His reasoning might arise from a desire to avoid ritual impurity. Michel Gourgues argues that “These leading examples of law-observant people do not aid the stripped and apparently dead man for fear of becoming defiled.”¹⁵ However, the Levite was not heading toward Jerusalem to fulfill his duties; he was also returning from Jerusalem. It is possible that his failure to intervene, based on the

¹⁵ Michel Gourgues, “The Priest, the Levite, and the Samaritan Revisited: A Critical Note on Luke 10:31-35,” *Journal of Biblical Literature* 117, no. 4 (1998): 709.

authoritative prohibition posed by Leviticus 21 that applied to the Priest the same regulation did not apply to the Levite.¹⁶

The Lord said to Moses, “Speak to the Priests, the sons of Aaron, and say to them: ‘A Priest must not make himself ceremonially unclean for any of his people who die, except for a close relative, such as his mother or father, his son or daughter, his brother, or an unmarried sister who is dependent on him since she has no husband—for her he may make himself unclean. He must not make himself unclean for people related to him by marriage, and so defile himself. (Lev. 21:1-4).

In Christian Doctrine, Augustine emphasizes that the Samaritans' act of compassion should serve as a standard for everyone in need of kindness. He believed we should see as our neighbor as anyone who shows compassion for us.¹⁷ By stopping to help the injured man, the Samaritan demonstrated tenderness, warmth, and affection. Although affection is not love, it can lead to love. Love and affection both entail care and connection, but they differ in that love is deeper and encompasses commitment, loyalty, and respect.

This is the love that God commands: love that is selfless and seeks the well-being of others. The inn, where the Samaritan took the injured man, was a place for travelers to rest, aiding in the injured man's recovery. It served weary travelers by providing care and acted as a place of public lodging. Augustine connects the inn to the church: “Augustine says that the man of the parable first had to recover in the inn, which is the church.”¹⁸ While the inn serves as a place to rest, the innkeeper is the host, the one who welcomes

¹⁶ Gourgues, “The Priest,” 709.

¹⁷ Augustine, *De Doctrina Christiana I*, edited and translated by R.P.H. Green (Oxford, England: Oxford University Press, 1996), 67-68; this book dates to 397 C.E.

¹⁸ Riemer Roukema, “The Good Samaritan in Ancient Christianity,” *Vigiliae Christianae* 58, no. 1 (2004): 70.

those who enter. To use Augustine's example, the church—the community of people who believe in and worship Christ—united in faith and fellowship, serving as a refuge for the weary and hurting, thus allowing them to recover and regain strength in both their bodies and their spirits and mind.

This does not imply that this is the only conclusion to be drawn from this parable. Specifically, John Welch asserts, "The word parable, however, does not fully describe the story of the Good Samaritan."¹⁹ Augustine referenced Origen's allegorical interpretation, proposing that humanity was created with free will and highlighting that this free will was lost when mankind sinned.²⁰ The Hebrew translation of the Samaritan name is "guardian," and as Augustine indicates, it is significant for understanding the full meaning of this parable. "Origen concludes that this guardian of the souls, who showed his compassion to the wounded man not only in words but also in deeds, has become a neighbour for him, and was closer to him than the law and the prophets."²¹ Augustine interprets this parable as symbolizing the oil and wine of baptism, representing the remission of sin. Baptism restores free will, and the inn signifies the church, where one is healed and the requirement for entering the kingdom of heaven.²² This aligns with God's commandment, as it embodies His unconditional love. Arguably, even Augustine had thoughts about interpreting biblical literature: "While Augustine's nuanced understanding of Scriptural interpretation allowed him to resolve potentially problematic biblical

¹⁹ John W. Welch, "The Good Samaritan: A Type and Shadow of the Plan of Salvation," *Brigham Young University Studies* 38, no. 2 (1999), 53.

²⁰ Roukema, "The Good Samaritan in Ancient Christianity," 69-70.

²¹ Roukema, "The Good Samaritan in Ancient Christianity," 65.

²² Roukema, "The Good Samaritan in Ancient Christianity," 69-70.

passages, his intensely intellectual approach also created a tension between divine guidance in biblical study and conventional, earthly academic study.”²³ Additionally in Book V of his *Confessions*, Augustine observes, In the end, everyone who claims to understand the complexities of Scripture through divine illumination, despite not having been taught any rules of interpretation, also believes—and rightly so—that this ability does not originate from themselves but is a gift from God.²⁴ In this context, Augustine firmly believed that a proper interpretation of Scripture depended on divine assistance. “Augustine suggests the active force of interpretation. In fact, one could say that for Augustine love activates knowledge. It enables knowledge or truth to enter and make a difference in the world of quotidian affairs.”²⁵

While there are varied perspectives on how parables should be deciphered, Jesus’ messages were descriptive and consistent in theme, proclaiming that the Kingdom of God has come, which was His primary objective. That message has a decisive impact on the world and humanity.²⁶ God extends that impact—one of love, care, selflessness, and compassion—to everyone. Some view the parable of the Samaritan as one of Jesus’ most influential stories, interpreting it as a straightforward lesson.

The initial step in Charles W. Hedrick’s “listener’s guide” for hearing the parables (which he hopes will help place readers “in the audience at a parable’s first audition”)

²³ Robert A. Ziegler, “Augustine of Hippo’s Doctrine of Scripture,” *Primary Source* 5, no.2 (2015): 34.

²⁴ Robert A. Ziegler, “Augustine of Hippo’s Doctrine of Scripture,” *Primary Source* 5, no.2 (2015): 34.

²⁵ Michael Vander Weele, “Augustine and Interpretation in ‘On Christian Doctrine’ and the ‘Confessions.’” *CEA Critic* 47, no.4 (1985): 13-21.

²⁶ Welch, “The Good Samaritan,” 51.

advises students to start by releasing these tales from their canonical moorings, because “a parable will never speak in its own way as long as it is embedded in a literary context.”²⁷ Since parables are spoken at specific times, events, and situations, removing them from their literary context could misconstrue the message. However, one could argue that the context does not convey the comprehensive thought of the parable if viewed only within its literary framework. Jesus’ parables challenge people’s thinking. In the case of the Samaritan, how did this law expert perceive the Kingdom of God?

While this parable appears to end conclusively with a simple, direct meaning, it is complex. Anderson explains:

Luke was at times heavy-handed and none too subtle in his treatment of the parables is substantiated in the forgoing analysis. At the same time, the charge that he domesticated a shrewd and polyvalent Jesus tradition does not sufficiently acknowledge that it is precisely in these now domesticated parables that the creative genius of Jesus is still recognized.²⁸

Jesus designed his parables, including this one, to offer a different perspective of who He is and what the Kingdom of God looks like. Ferguson argues that “the main concern of Jesus in his parables was the essential character of the kingdom and its absolute demands.”²⁹ Many of the parables Jesus presented had similar themes and “reinforced Jesus’ teaching about the kingdom as bringing a sense of urgency and unexpected opportunity.”³⁰ Jesus’ parables should not be dismissed as mere storytelling but as an

²⁷ Charles W. Hedrick, *Many Things in Parables: Jesus and His Modern Critics* (Louisville, KY: Westminster John Knox, 2004), 90.

²⁸ Garwood P. Anderson, “Seeking and Saving What Might Have Been Lost: Luke’s Restoration of an Enigmatic Parable Tradition,” *The Catholic Biblical Quarterly* 70, no. 4 (2008): 749.

²⁹ Ferguson, *The Everlasting Kingdom*, 48.

³⁰ Ferguson, *The Everlasting Kingdom*, 48.

opportunity to enlighten minds, change thinking, and understand the vastness of His being, His love, godly love.

Bovon and Deer suggest that this pericope of scripture in Luke 10 is not just about the parable of the Good Samaritan but offers more to consider. Herein is an example of polyvalence:

This pericope is not limited to the parable. The parable is caught up in a debate the stakes of which are access to eternal life. Jesus and the man with whom he is in dialogue agree on appealing to Scripture and on linking eternal inheritance with practice of the Law. The purpose of the parable is to answer a specific question: Who is my neighbor? Essentially, however, it still has an exegetical and ethical character and is linked to the commandment to love one's neighbor. But that character serves as an intermediary that establishes a link with our love for God and God's love for us."³¹

Through the parable of the Samaritan, everyone can reflect on their actions towards others, highlighting the importance of not only knowing the law but also practicing it. Jesus aimed for a thorough understanding of not just what was written in the law but also of the Kingdom of God and the kind of character it calls for. This parable illustrates what God desires from those who follow Him and aspire to live eternally with Him.

Western civilization defines a neighbor as someone nearby, primarily next door, within a close living space.³² In Jewish thought, "brother" and "neighbor" are used to limit the commandment to transactions within the Jewish community."³³ Jesus presents a

³¹ François Bovon and Donald S. Deer, "The Samaritan or Eternal Life as an Inheritance (10:25-37)." In *Luke 2: A Commentary on the Gospel of Luke 9:51-19:27*, edited by Helmut Koester (Minneapolis, MN: 1517 Media, 2013), 51.

³² "Neighbor," Oxford English Dictionary, <https://www.oed.com/search/dictionary/?scope=Entries&q=neighbor>.

³³ Joshua Heller, "Between Brothers and Neighbors," JTS Torah Archive, JTS, last modified May 17, 2003/5763, <https://www.jtsa.edu/torah/between-brothers-and-neighbors/>.

broader understanding of the meaning of neighbor, removing the idea of geographical proximity. Anyone and everyone is a neighbor, yet in Western civilization there are various nuances when interacting with others (neighbors). People consider personal behaviors, beliefs, environments, and habits when interacting with others.

This parable often focuses on the actions of the Samaritan but also involves several others. Most notable is the Samaritan himself. Although ample attention is given to the Samaritan, each character represents someone or something. The Samaritan, for example, is the one who does what is right. Note that the Bible does not refer to him as “good” but rather as someone who does the right thing. The wounded man could be anyone.

The adjective “good” is not in the text. Is it an unwarranted projection? Since the name “Samaritan” brings to mind someone who is marginalized, a member of a disdained community, the traditional title expresses the paradox very well: the bad person is not the person that one would think. On the other hand, the use of the adjective “good” has its down side, in that it is attached to the person, whereas what counts is what the Samaritan does; moreover, this use runs the risk of reducing the parable to a moral lesson³⁴

The Samaritan demonstrates a kind of love, compassion, and kindness that is free of prejudice. This is the responsibility that all Christians are asked to adopt. It is not limited to a specific group but extends to all of humanity. It exemplifies what Christian love should look like and how it is expressed. Researchers suggest that “All major world religions preach universal compassion. They call us to care for the welfare of all others poor as well as rich, weak as well as strong, foe as well as friend (Burt 1957).”³⁵

³⁴ Bovon and Deer, “The Samaritan or Eternal Life,” 51.

³⁵ C. Daniel Batson, Scott H. Eidelman, Seanna L. Higley, and Sarah A. Russell, “‘And Who Is My Neighbor?’ II: Quest Religion as a Source of Universal Compassion,” *Journal for the Scientific Study of Religion* 40, no. 1 (2001): 39.

Before the Samaritan saw the injured man, two others observed him and avoided him instead of offering assistance. Did Jesus purposely leave out the wounded man's identity, race, and condition? Instead, significant focus was on the actions of those who did not offer help. The injured man's nationality was not the focus; his condition and the actions of those who encountered him were where Jesus drew attention.

The innkeeper is often overlooked in interpretations of this parable. While his role appears non-essential, he too offered aid when others did not. He provided not only sustenance and lodging but also trust. When the Samaritan brought the injured man to the innkeeper, he only gave him "two denarii," (what he had), promising to return the next day for any additional expenses incurred (Luke 10:35). The Samaritan provided what he could, bandaging the injured man's wounds and pouring oil and water on him (Luke 10:34). The innkeeper offered food, lodging, and additional care; each did what was within their capacity to do. This illustration shows that the meaning of neighbor is enhanced by one's actions and attitude.

The Apostle John records how the law should be understood in the context of loving one's neighbor and its significance for inheriting eternal life: "A new command I give you: Love one another. As I have loved you, so you must love one another. By this everyone will know that you are my disciples, if you love one another" (John 13:34-35).

The Samaritan illustrates the importance of showing compassion, mercy, and unconditional love, while remaining impartial and altruistic and demonstrating God's righteousness. The injured person was hurt and unable to help himself, yet those who could assist him ignored and avoided him. The innkeeper was the host who trusted a stranger, which exemplifies another demonstration of compassion and mercy. The Priest

and the Levite, as intercessors and leaders, should exemplify godly living by demonstrating compassion, mercy, and genuine concern. Proctor explains that it is,

Through a metaphorical story that Jesus reveals the truth of the law and the responsibility to observers of the law. In asking the lawyer to interpret for himself, he is enlightened. Through the parable he sees what he did not see when simply reading the law. In his reflection, Samaritans were more pious than himself, “those who have shown mercy.” This realization serves as the ground for Jesus’s request that he “go and do likewise.”³⁶

What matters is not merely the interpretation and knowledge of God’s law, but the practice of the law. Jesus aimed to show him what constituted God’s kingdom, redirecting the law experts’ focus from legalistic self-interest to an inward assessment of his motivations, which we, too, must undertake. Jesus did not instruct the lawyer on what it means to love a neighbor. Instead, through the parable of the Samaritan, he demonstrates what love for neighbors truly looks like.

Jesus deliberately engages this man in a discourse to open his mind to the truth of God’s law as well as a New Covenant. No longer were sacrifices necessary for forgiveness, and all people were invited to become children of God. Jesus was the atoning sacrifice. “Jesus’ teachings about the nature of the kingdom and the demands it makes are a special warning to church members”³⁷ To think solely about oneself is to disregard others. We are not islands existing without support from others. We are a community of people defined as humanity, and we should regard all people as such. “Jesus’ teachings are a message, in fact, to everyone. To all he says that we should follow

³⁶ Mark A. Proctor, “‘Who Is My Neighbor?’ Recontextualizing Luke’s Good Samaritan (Luke 10:25–37),” *Journal of Biblical Literature* 138, no. 1 (2019): 203.

³⁷ Ferguson, *The Everlasting Kingdom*, 58.

God's design for our lives"³⁸ The law expert knew, in part, what was necessary to inherit eternal life. Still, he somehow missed his responsibility to others—all others—for we are all one in Christ Jesus (Gal. 3:27-28). The benefit the law expert received from loving God involved only himself. Jesus communicated that it goes beyond that; there are others for whom we all bear responsibility. If the law expert understood the parable correctly, the resulting action would be compassionate care for everyone. God's command encapsulates care, obedience, and an understanding of all the essential features of responsibility. One way to show how this is done is through the exegetical discourse Jesus conducted to aid in uncovering the interpretation of the law and the actions one should take.

The Samaritan parable teaches Christians to be driven by emotional and passionate care when addressing the needs of others, including their psychological well-being, which encompasses spiritual, physical, and emotional needs. They should recognize a need and respond within their ability. A Christian's entire being—thoughts, actions, soul, and breath—should be directed towards loving the Lord, and that love must be accompanied by action. If the law expert seeks eternal life, he is required to embrace the command with a renewed understanding. Inherently, the parable of the Samaritan is not characterized by legalese but by an exploration of human relationships and thought. It prompts listeners to ask how we are to treat one another. Is it based on a person's identity, community status, or ability to reciprocate the behavior? No, it is about none of these. Jesus' purpose in telling this parable is to challenge those with book knowledge to

³⁸ Ferguson, *The Everlasting Kingdom*, 58.

consider the intrinsic part of humanity, the soul of humanity. The parable raises questions about what makes a person human and who should be given dignity and worth.

Human relations are complicated due to several factors, including cultural differences, familial backgrounds, and language barriers; the list is endless. Is loving someone like yourself possible?

The characters in the parable of the Good Samaritan (Luke 10:25-37) illustrate human relationships instead of the divine-human relation; the action is atypical in a not unlikely situation. When a Samaritan was introduced into the story, the situation was jolted out of normalcy: immediately unfavorable comparisons with the religious elite were unavoidable, and Jewish listeners identifying with the victim would feel repelled by a Samaritan ministering to a fellow Jew.³⁹

Jesus did not make distinctions, as seen by His encounter with a Samaritan woman at a well (John 4:1-26). God used the parable of the Samaritan to exemplify divine truth. This realization serves as the grounds for Jesus's comment to "go and do likewise" (Luke 10:37 b).

Identifying human needs is challenging. Knowing when to offer assistance requires deliberate observation. Caring for others and neighbors necessitates awareness and willingness, much like the compassion shown by the Samaritan. Both good and bad people can possess varying qualities based on their individual principles. The Samaritan was ready to see, assist, care for, and follow up to ensure that someone in pain received help. This is the message Jesus imparted, urging His followers to do the same. It is part of the Great Commandment to love our neighbors as we love ourselves. It is a call to

³⁹ Huffman, "Atypical Features in the Parables of Jesus," 214.

respond to the needs of others, doing what we can and sharing the love of God with them through our attitudes and actions.

Summary

The focus of this project is on mental health, specifically clinical depression, which is defined by characteristics such as anxiety, sadness, hopelessness, depression and more.⁴⁰ Mental health encompasses an individual's psychological and emotional well-being, including how one thinks, feels, and acts. In the parable of the Samaritan, Jesus teaches that it is our responsibility as Christ's followers and as a Christian community to show compassion and help those in need. For those struggling with distress (anxiety and depression), we often do not have the capacity or skills to provide psychological help unless trained in that field. However, the conditions that may perpetuate these feelings, such as providing food for the hungry or offering clothing and shelter, can be addressed. Sometimes, those who are suffering just want someone who is willing to listen. This parable is about caring for others in the way that God intended. That responsibility begins with identifying and addressing those needs as one can.

We must not be insensitive to the needs of others, nor should we ignore them in our religious piety or leadership roles within the church. Furthermore, while other interpretations can be derived from this parable, the foundation of this exegesis lies in understanding the context of neighbor and how being a good neighbor can influence a

⁴⁰ Hall-Flavin, Daniel K., "Clinical Depression: What Does That Mean?" Mayo Clinic, last modified May 13, 2017. <https://www.mayoclinic.org/diseases-conditions/depression/expert-answers/clinical-depression/faq-20057770>.

person's life. For this paper, this parable emphasizes that everyone is our neighbor and that exhibiting compassion is one of many ways to provide aid.

Much of the problem is that even those who are familiar with the Good Samaritan story in a pious context almost automatically contract their notion of neighbor in everyday life, though the traditional interpretation indicates our responsibility to the outcast-and even our enemies. As Vincent Harding reminds us in his moving review of Martin Luther King's career, it is easier to respond to the claims of justice when the issues are not on our doorstep."⁴¹

As it applies to mental health, the term may be seen as uncomfortable and tends to frighten people away because of the perceived nature of the illness. It is essential to understand that mental health does not need to be frightening and that anyone can experience episodes of anxiety and depression at any time. Whether it is the loss of a loved one perpetuating grief, the loss of a job resulting in loss of income and a way to care for oneself, a child facing a bully in school, a medical diagnosis, or other everyday occurrences, these can all lead to feelings of discomfort, anxiety, or depression. These are not individuals to avoid; instead, we should engage with and support them. This is part of loving your neighbor and fulfilling God's command. When someone is mistreated in one place, they often make such treatment acceptable elsewhere. That is injustice. Everyone in the church has a responsibility to fulfill God's commandments; believers are called to follow Jesus. Whether you are the Priest, the Levite, the Samaritan, or the innkeeper, every person has a role and responsibility in helping one another, and this should not be overlooked. This parable illustrates that needs can be recognized.

Some people suffering from distress may not be as apparent as the man in the story of the parable. However, their needs can be identified through congregants' actions,

⁴¹ Joseph Cunneen, "The Good Samaritan: Parable of Renewal," *CrossCurrents* 46, no. 3 (1996): 291.

conversations, and training to recognize the signs of someone in distress. Still, like the Priest and the Levite, it is possible to ignore a need even when noticing it. The objective is to recognize and address the need. You may not be the one who can help, but you can listen and, as the Samaritan did, guide them to a resource who may be able to assist.

The Samaritan's compassion and selflessness, the innkeepers' trust, and unfortunately, the disregard of the religious elite represent how some are treated today. The Samaritan did not completely fix the injured man's problems; he just addressed the issues he could. The ability to address all aspects of the needs of distress may appear daunting, but having an open ear without judgment, guiding individuals to help, and acknowledging that they do not have to suffer in isolation is an act of love. Trainings are available to help identify signs that indicate care is needed. It would offer an open door where congregants can share their concerns and openly discuss mental health in teaching and preaching.

According to WHO (the World Health Organization), "There are many types of mental health disorders."⁴² Yet, according to Psychology Today, people remain reluctant to go to therapy for a variety of reasons, including the stigma surrounding therapy, fear of looking weak, fear of change, therapy being too expensive and time-consuming, family resistance toward therapy, therapy being hard work, and lack of confidentiality.⁴³ All these reasons discourage individuals from seeking help. Where can they find the guidance they need to address their mental well-being? A Barna study found that 44% of

⁴² "Mental Disorders," Fact Sheets, World Health Organization, last modified June 8, 2002, <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>.

⁴³ Robert C. Ciampi, "Why Are People Still Reluctant to Go to Therapy?" *When to Call a Therapist* (blog), *Psychology Today*, October 11, 2020, <https://www.psychologytoday.com/us/blog/when-call-therapist/202010/why-are-people-still-reluctant-go-therapy>.

people surveyed would attend mental health programs if they were offered at a church. The church offering such programs would create an environment where those suffering can begin to allow themselves to receive direction toward help.

The need for mental health care is trending upward. According to the American Psychological Association (APA), ninety percent of the public believes there is a mental health crisis in the United States.⁴⁴ Survey results from 2022 conducted by the APA indicated:

"One-third of respondents could not get the mental health services they needed. When asked about the specific barriers to accessing care, 80% cited cost and more than 60% cited shame and stigma as the main obstacles. The shortage of mental health providers is also prohibitive, with 60% of psychologists reporting no openings for new patients."⁴⁵

Many people face challenges with their mental health. Data indicate that a significant number of individuals who need help do not seek therapy. These figures highlight the urgent need for those suffering to access support. Because of shame, stigma, and the lack of available psychologists, many continue to endure in silence. The church has a significant opportunity to impact lives, particularly for those dealing with anxiety and depression. People attend church voluntarily; typically, those who come trust their leaders. Often, pastors are the first people congregants approach when facing distressing situations. However, trained church leaders can also play a vital role. Implementing a program to train church leaders to recognize the signs of anxiety and depression could provide a valuable resource.

⁴⁴ Heather Stringer, "Mental Health Care is in High Demand. Psychologists are Leveraging Tech and Peers to Meet the Need," *Monitor on Psychology* 55, no. 1 (January 2024): 60.

⁴⁵ Heather Stringer, "Mental Health Care is in High Demand. Psychologists are Leveraging Tech and Peers to Meet the Need," *Monitor on Psychology* 55, no. 1 (January 2024): 60.

If we are obedient to God's commandment, our acknowledgment should be demonstrated in what we do. Ignoring the needs of others is to ignore God's command, which includes mental health. The Bible should be taught with special care, remaining contextually sound, leading those who hear its words to desire to follow God's laws and seek to care for others. Incorporating biblical sermons and teachings that focus on mental health can help remove the stigma and enable those who might not normally seek care to understand that God's word can guide the suffering toward assistance. Such help means that those who are well should do what they can, selflessly, to assist a fellow brother or sister. This may take the form of time or resources, addressing situations on a case-by-case basis.

Although it may not be possible to predetermine a person's needs, observing a need or hearing about it should prompt action; this action should be taken not for ourselves, but as if we were doing it for God. Christian teaching emphasizes caring for others, and as needs are recognized positive outcomes can result. "Whatever you do, work at it with all your heart, as working for the lord, not for human masters" (Col. 3:23).

CHAPTER THREE

HISTORICAL FOUNDATIONS

Introduction

While the term "mental health" has existed for centuries, mental health as a discipline did not emerge until 1946.¹ Today, there is an acute awareness that people struggle with mental health. Statistical data indicates that more than one in five adults live with mental illness.² The absence of the term "mental health" in historical records does not mean that people have not faced mental disease throughout history. The Bible identifies many individuals who suffered from mental health issues: Hannah suffered mentally while struggling with infertility, Elijah experienced depression, Job faced radical loss, David experienced anxiety, Jonah wanted to die, and, most notably, Jesus endured such great dread that he sweated blood in the Garden of Gethsemane.

These are just a few of the many individuals mentioned in the Bible who suffered from mental health issues. Their diverse experiences illustrate the widespread impact of mental health and the importance of mental health awareness. Many factors can affect mental health, including genetic predisposition and a lack of physical care, social factors

¹ José Bertolote, "The Roots of the Concept of Mental Health," *World Psychiatry* 7, no. 2 (June 2008): 113-6, <https://doi.org/10.1002/j.2051-5545.2008.tb00172.x>.

² National Institute of Mental Health, "Mental Illness," Statistics, Mental Health Information, last modified March 2023, <https://www.nimh.nih.gov/health/statistics/mental-illness>.

such as family, financial stability, housing, discrimination, and racial injustice, and other factors like stress, the death of a loved one, domestic violence, adverse childhood experiences, and abuse. No matter how sincere or zealous one may be in faith, there are times when one needs the help and support of others.

Mental health and wellness are essential to overall health. The World Health Organization defines health as "...a state of complete physical, mental, and social well-being."³ Mental health is defined as a "state of being that includes our emotional, psychological, and social well-being. It affects how we think, feel, and act, and helps determine how we handle stress, relate to others, and make choices."³ Having someone supportive, especially regarding anxiety and depression, may help reduce suffering. Hannah, Elijah, Job, David, and Jonah faced situations affecting their emotional well-being.

Often, people are told to have faith in God as an antidote to their suffering. However, the Bible also provides instruction on how faith believers can assist and provide guidance. Not everyone has a relationship with God that brings clarity, direction, or care. In scripture, Christians are told to care for each other (1 Cor. 12:25-27). Ecclesial Christian action involves engagement with others, providing care, direction, and ultimately, love. William and Catherine Booth, founders of The Salvation Army, a Protestant Christian Church, demonstrate how ordinary people can come alongside those in need and provide resources and care so that they can live more fruitful lives. William's awareness of the suffering of the poor in England and his internal drive and compulsion

³ World Health Organization, *Investing in Mental Health* (Geneva, Switzerland: World Health Organization, 2003).

started a movement that has lasted more than 100 years. While seeking to bring salvation to the masses, their ministry identified greater needs.

William and Catherine Booth recognized that to fulfill their mission of salvation, they needed to address the physical and emotional needs of those they aimed to reach. Preaching salvation when someone is homeless, hungry, or unable to satisfy immediate physical needs is futile.

Booth's theology required a resolution to the problem of evil, but it called more specifically to an end to human misery and suffering caused by such forces as the wickedness of parents, crime, vices, evil passions, drunkenness, poverty, hunger, disease, and the infliction caused by selfishness, greed, hatred, jealousies, envying, and revenge.⁴

It was because he conflicted with the Methodist establishment that led Booth to issue a resignation from the New Connexion ministry in 1861 (The Methodist New Connexion was a Protestant nonconformist Church where William Booth was ordained)⁵ so, "he took to the streets of London in an effort to preach the gospel of Jesus Christ and to meet human needs in His name without discrimination (Salvation Army, 2005a)."⁶ It was because of this denial that Booth took to the streets to share his message with those who were not welcomed inside the church building, and it was there that he felt compelled to address the needs of the people before preaching a message of salvation.

Leaving The Methodist New Connexion was instrumental in his mission of saving souls, but the immediate needs had to be met first. Booth's approach began with first

⁴ Roger J. Green, "William Booth's Theology of Redemption," *Christian History* 26 (1990).

⁵ Norman H. Murdoch, "The Salvation Army and the Church of England, 1882-1883," *Historical Magazine of the Protestant Episcopal Church* 55, no. 1 (1986): 32.

⁶ Brandi Schorey and Christopher Bradley, "Dismantling the Battle Plan: An Exploratory Study of the Practices of the Salvation Army," *Michigan Sociological Review* 19 (2005): 64.

seeing, understanding, and meeting needs through acknowledgment and compassionate care. This kind of compassionate care can work today with individuals who care about the distress and needs of others. Simple gestures like offering encouragement, listening, helping individuals find support, and doing what you can to guide them to a place of healing. In the classic words of William Booth, “You cannot warm the hearts of people with God’s love if they have an empty stomach and cold feet.”⁷

The Salvation Army

The Salvation Army is a worldwide church, but it originated with the work of one man—William Booth. Booth’s early experiences influenced his life purpose. Born in Nottingham, England, on April 10, 1829, to Samuel Booth and his second wife, Mary, from Derbyshire, England, he started working after his father passed away when he was fourteen to help support the family's income. By the age of fifteen, he became a Christian and a communicant of the Wesleyan Methodist Church, where he experienced his spiritual awakening. He was so passionate about his ministerial work that at seventeen he began preaching in the streets during his spare time.⁸ Booth was called to the preaching ministry at nineteen and became a fully ordained minister in 1857. Despite receiving minimal schooling and formal ministerial education, his overpowering presence and compelling oratory skills made him an influential revivalist.

⁷ Yaw Perbi, “A Hungry Student Cannot Hear the Gospel,” Ministry Update, International Student Ministries Canada, May 19, 2021, <https://ismc.ca/a-hungry-student-cannot-hear-the-gospel/>.

⁸ Herbert Wisbey, Jr., *Soldiers Without Swords: A History of the Salvation Army in the United States* (New York, NY: The Macmillan Company, 1955), 16.

Historians suggest that “Three ideas motivated Booth’s life: he was determined to get on in the world: he possessed an ambition to ameliorate the miseries of the poor, and he longed to get back to God.”⁹ Convinced that everyone needed to hear the message of salvation, Booth believed Christians were responsible for ministering to the poor and neglected. Driven by his desire to bring revival to the Methodists of his native land and to impact the working class, Booth began his preaching ministry in England in 1852. However, he soon became disillusioned with the traditional Church. Booth believed that the Church should not be confined within the walls of a building but should instead operate out in the streets where the people were, just as Jesus did.

William’s wife, Catherine Mumford Booth, was an equally formidable character. Born in Ashbourne, Derbyshire, on January 17, 1829, she had a strong Christian foundation, and unlike her husband she received significant education, primarily at home. “Attracted to the writings of Wesley, Fletcher, and Finney”¹⁰ “her training under the tutelage of her mother has been described as training of the soul and shaping of character.”¹¹ By the age of twelve, she had read the Bible eight times.¹² At the age of sixteen, her faith deepened, and she became fully immersed in it. Like William, Catherine had a heart for the underserved. For Catherine, joining William in ministry or becoming

⁹ William McCallion, “The Salvation Army,” *The Irish Monthly* 74, no. 881 (1946): 466.

¹⁰ Mary Agnes Maddox, “The Aggressive Christianity of Catherine Mumford Booth,” *The Salvation Army* 22, no. 3 (Summer 2008):.

¹¹ William McCallion, “The Salvation Army,” *The Irish Monthly* 74, no. 881 (1946): 466.

¹² “Founders William and Catherine Booth,” Our History, About Us, The Salvation Army Australia, <https://www.salvationarmy.org.au/about-us/our-story/our-history/founders-william-and-catherine-booth/>.

his wife required certain conditions. Specifically, women would be allowed to preach.¹³

William and Catherine married in 1855 and had eight children in the formative years of the army.

Catherine brought evolving views on women's roles in ministry to her marriage. Earlier in her life, she adhered to more restrictive views of gender roles in ministry. However, a year before meeting William she came to believe that the Bible taught women could have a role in the preaching ministry. While this change was triggered by a demeaning letter sent to a London clergyman regarding women, Catherine developed these views and overcame her initial hesitations through her study of the Bible. Eventually, she believed that God intended for women to be leaders and preachers in the Church. She could be considered a feminist for her insistence on sharing an equal role with her husband and advocating for the same opportunities for all women of The Salvation Army as she had. She “argued the innate equality of women and promoted them to clerical parity with men.”¹⁴ Catherine provided supporting scriptures to convince William of their truth. Through Catherine’s guidance and conveyance of the scriptures, William eventually came to share a similar belief.

Some have argued that Catherine was more effective than William in reaching the community. Catherine worked tirelessly alongside her husband as they ministered to those deemed “the poor and wretched.” She became known as the Mother of the Army and comforted William in his work. She served as a stabilizing force and an encourager.

¹³ “Founders William and Catherine Booth.”

¹⁴ “Founders William and Catherine Booth.”

William and Catherine began their message of reaching the underserved in the streets of London in 1859 in the form of a revival. By the end of 1860, touring as independent evangelists, they began ministering in the East End of London. Those to whom they ministered were some of the poorest in the capital.¹⁵ Five years later on July 2, 1865, William and Catherine Booth founded the East London Christian Mission, renamed The Salvation Army in 1878. Their goal was to offer salvation to those who would not otherwise hear the message of Jesus' death and resurrection, which saved people from separation from God and brought restoration and eternal life.

Booth sought acceptance from other churches partly due to the Salvation Army's need for financial support. However, he faced a dilemma: aligning himself with the established church would require adherence to their doctrines, disciplines, and practices, which would compromise his control over the organization. Booth and the Church of England held differing views regarding the army's doctrines and disciplinary practices. Of particular concern was the administration of the sacraments; by 1882, Booth decided that sacraments were unnecessary for salvation. Attempts to merge with other churches were met with uncertainty. Yet urban areas throughout England grew in the late 1800s, and clergy in the Church of England could not relate to this community because of their particular pedigree.

Booth's dream of reaching the masses would be accomplished through challenges, controversies, and a reassessment of the Army's tenets and practices. The Salvation Army's current website explains, "The Salvation Army's relationship with

¹⁵ "Founders William and Catherine Booth."

other religious sects in the 1880s alternated between friendship and hostility.”¹⁶ The way the Salvationists (as they were referred to) carried out their mission was considered vulgar compared to traditional Church worship. Yet, the “established Churches” at least initially agreed that the traditional Church would not reach those Booth and his organization would, so they were willing to overlook their atypical way of saving souls.

Initially, Booth aimed to connect the individuals in the street with existing churches. However, the wealthy and respectable members of local churches did not welcome those to whom he ministered.¹⁷ This confused Booth because he believed that salvation was meant for everyone and that no one should be excluded from the Church due to low social status.

The streets of London were crowded with people living in slums and abject poverty. Filth and disease were prevalent, crime was high, prostitution widespread, and infant mortality rates elevated, leaving a palpable sense of despair and insecurity.¹⁸ The overall conditions were deplorable. These are the people William Booth felt compelled to bring salvation to. What difference would salvation make if day-to-day needs were not being met? The Booths realized they needed to change their strategy if they wished to save souls.

Facing rejection, antagonism, and a lack of financial support from the Church, the Booths forged ahead with an initiative that would eventually exceed their expectations

¹⁶ “What We Believe,” The Salvation Army, <https://www.salvationarmyusa.org/usn/what-we-believe/>.

¹⁷ “History of the Salvation Army,” Soundpoint Youth and Community Centre, The Salvation Army Australia, <https://www.salvationarmy.org.au/soundpoint/about-us/history-of-the-salvation-army/>.

¹⁸ Stephen Huggins, *The Mob and The Mayor: Persecution of the Salvation Army at the Victorian Seaside* (Liverpool, UK: Liverpool University Press, 2020).

and impact millions worldwide. “Rejection has serious implications for an individual’s psychological state and for society in general. Social rejection can influence emotion, cognition and even physical health.”¹⁹ It can also increase anxiety, depression, jealousy, and sadness.²⁰ “As researchers have dug deeper into the roots of rejection, they have found surprising evidence that the pain of being excluded is not so different from the pain of physical injury. Rejection also has serious implications for an individual’s psychological state and for society in general.”²¹

The Booths realized that the only way to accomplish their mission was to address the immediate needs by understanding the mood of the people. Fundamentally, the mission of the Booths, while rooted in salvation, became convinced that until the connection between the spiritual and the distress experienced was addressed, it would be a mockery to talk about people’s souls.²² Their vision was not an integrated mission that encompassed the whole person, body and soul; however, its work became diverse.²³ Salvation was their primary mission, but through insight gained, William Booth began to realize the need for something more than his initial approach. He felt it was a God-given understanding of what is sometimes called The Salvation Army’s second mission.

This was really the beginning of the Salvation Army’s understanding of integrated mission. It was William Booth’s later theology that moved him, and therefore The Salvation Army, into its second mission-caring for humanity’s physical, emotional, and

¹⁹ Kirsten Weir, “The Pain of Social Rejection,” *Monitor on Psychology* 43, no. 4 (April 2012): 50. <https://www.apa.org/monitor/2012/04/rejection>.

²⁰ Weir, “The Pain of Social Rejection,” 50.

²¹ Weir, “The Pain of Social Rejection,” 50.

²² Mary Agnes Maddox, “The Aggressive Christianity of Catherine Mumford Booth,” *The Salvation Army* 22, no. 3 (Summer 2008): 7.

²³ Carolyn J. R. Bailey, “The Salvation Army and the United Nations—Being Good Neighbors,” *CrossCurrents* 60, no. 3 (2010): 359.

social needs as well as working for social justice. “(William Booths)” later theology of redemption still included personal salvation from sin for the individual who believes by faith; his later theology of redemption developed in such a way that it included social salvation from the evils that beset people in the world.²⁴

The East London Christian Mission (as The Salvation Army was initially known) addressed a key area of lack in the existing Church landscape. Author Stephen Huggins explains, “The Church of England lacked a parish system which was capable of meeting the needs of the emerging urban areas, while many of their clergy were from upper and middle-class backgrounds and lacking in understanding of life in the slums.”²⁵ Additionally, the Church's wealthy and upper-middle-class supporters were disinterested in investing in those they perceived as lazy. Consequently, Booth's work was greatly needed. Eventually, over 1,000 volunteers and evangelists joined the Christian Mission. Booth recognized a need and acted on what he observed, inspiring others to believe in him and his initiative, joining his fight to save lost souls.

The Salvation Army took a bold stance and was regarded as unconventional and egalitarian in its ministry; the organization's focus on addressing both physical and spiritual needs led to pushback. This shift in The Salvation Army's approach to ministry emerged from Booth's observations as he walked the streets preaching and evangelizing. He realized that salvation was not the dominant concern for suffering souls. Instead, those living in poverty were primarily concerned about day-to-day living needs, which were an immediate cause of distress. Distress affects daily life, leading to a range of symptoms including depression, anxiety, withdrawal, hopelessness, irritability, fatigue,

²⁴ Bailey, “The Salvation Army and the United Nations,” 359.

²⁵ Huggins, *The Mob and The Mayor*, 5.

and other physical and mental manifestations.²⁶ The Salvation Army was initially formed to bring salvation to those otherwise rejected by society (thus the name “Salvation Army”). “Booth was stunned that animals were treated better than human beings.”²⁷ As The Salvation Army grew and its notoriety rose, it caused a stir in Victorian society. Salvationists (as they were referred to) had a formidable presence. They delivered raucous worship in the city streets, usually accompanied by loud music and singing. They were indiscriminate in sharing the gospel; the only thing that mattered was people’s salvation. The Salvation Army accomplished its mission by having men and women serve together. Huggins explains, “Victorian society did not really know how to respond to the rise of the Salvation Army whose radical approach to Christianity challenged the sense of security and firmly held assumptions of many.”²⁸

In time, however, William realized that successfully preaching salvation to the needy would require more than merely hearing what the Bible said; he would have to act on what the Bible taught. An analysis of the Salvation Army in the 1930s explains the organization’s views on the connection between physical and spiritual needs.

The Salvation Army is organized to save men spiritually and it has found that the most effective way is to minister to physical wants before speaking of religious matters. It is practical Christianity to deal with the man “without a job, enervated through privation or dissipation; the girl facing motherhood out of wedlock, dismayed and alone; aged men and women without homes in which to spend their declining years; the youth, realizing the futility of indulgence, but puzzled as to which way to turn; the criminal brooding in his cell; and the widow with her children, valiantly waging a losing battle against poverty and disease.”²⁹

²⁶ Margarita Tartakovsky, “How to Recognize Emotional Distress, Plus 5 Tips to Help You Cope,” Healthline, last modified May 13, 2022, <https://www.healthline.com/health/mental-health/emotional-distress>.

²⁷ Bailey, “The Salvation Army and the United Nations,” 360.

²⁸ Huggins, *The Mob and The Mayor*, 15.

²⁹ Dorsey D. Jones, “Drumhead Salvationists,” *Social Science* 6, no. 2 (1931): 176.

The Booths soon realized they could only achieve their mission once human needs were met. While interacting with the community, they observed and experienced individuals whose mental health was suffering. Mental health was not recognized as a science during the nineteenth and early twentieth centuries, and those suffering from mental health conditions, as understood today, were considered mentally ill and were committed to madhouses. “Booth believed ‘insanity was a robotic state that was entered by freewill choices to engage in sin and that they should be committed to asylums against their will and taken care of at tax payer expense.’”³⁰

Prevailing conceptualizations of mental illness at the beginning of the 19th century elevated highly stigmatizing views, likening mental conditions to demonic possession or moral deviance, and “mad” people were believed to have no abilities to “reason” and needed to be “tamed” (Penney and Stastny, 2008).³¹

The distinction between mental health and mental illness has evolved over the years due to a combination of research, increased awareness, and understanding.

The distinction between mental health and mental illness was unknown during Booth’s lifetime. However, his initiative through his work with the Salvation Army recognizes how mental well-being can positively affect an individual’s sense of well-being. He not only observed how the lack of basic needs affected people, but he also listened and took matters to heart. He listened with his ears and eyes, able to see the suffering all around. Booth demonstrates how a person's mental health can be positively influenced by being present and offering support. He recognized that adversity, suffering,

³⁰ William Booth, “In Darkest England and the Way Out,” Bible.ca, <https://www.bible.ca/psychiatry/in-darkest-england-and-the-way-out-william-booth-1890ad.htm>.

³¹ Preethy George, Nev Jones, Howard Goldman, and Abram Rosenblatt, “Cycles of Reform in the History of Psychosis Treatment in the United States,” *SSM. Mental Health* 3 (2023): 100205. doi:10.1016/j.ssmmh.2023.100205.

and misfortune create a recipe for hopelessness, anxiety, confusion, frustration, and anger, along with accompanying physical ailments, which are expressions of unmet needs. “Maslow’s theory of the hierarchy of needs holds that much of human behavior is motivated by unsatisfied needs and that lower-level needs must be satisfied before higher-level needs can be addressed.”³² Abraham Maslow’s theory, proposed in the 1940s, suggests that needs—what a person considers most important—are the priority, while those of lesser importance are secondary follow.

Abraham Maslow outlined a motivational hierarchy consisting of five categories of human needs arranged in ascending order: physiological—basic needs satisfied by such stimuli as food and sleep; security—need for a safe environment free from immediate threat; social—affiliative and love needs; a desire for social acceptance; esteem—need for enhancement and acceptance of self; and self-actualization—striving for full realization of unique characteristics and potentials.³³

By providing food, shelter, and jobs, Booth observed how the marginalized could lead productive lives.

Whilst Booth’s religious message never faltered, his social mission continued to grow, involving practical grass-roots charity work which tackled those issues which had been festering for far too long. The taboos of poverty, homelessness and prostitution were addressed by his programme, organising accommodation for those sleeping on the streets and providing safe refuge for vulnerable fallen women.³⁴

Long before Dr. Abraham Maslow introduced the hierarchy of needs, which includes physiological, safety, social, esteem, and self-actualization needs, William

³² George F. Hayhoe, “Why We Do the Things We Do,” *Technical Communication* 51, no. 2 (2004): 181.

³³ Seymour Adler, “Maslow’s Need Hierarchy and the Adjustment of Immigrants,” *The International Migration Review* 11, no. 4 (1977): 444.

³⁴ Jessican Brain, “William Booth and the Salvation Army,” Culture UK, Historic UK, <https://www.historic-uk.com/CultureUK/William-Booth-Salvation-Army/>.

Booth understood that you had to meet physical needs first before you could expect anyone to care about their spiritual well-being needs. Research shows that this lack of needs can contribute to poor mental health.³⁵ “Low self-esteem tends to work in a vicious cycle with other mental health conditions like depression and anxiety. It's hard to say which comes first, only that the combination is both common and troublesome. Someone who already lives with a mental illness may find that low self-esteem develops due to the social stigma surrounding mental illness. Stigma can perpetuate the feeling that they have somehow failed.”³⁶

William Booth observed people rejected by the Church: the poor, homeless, helpless, uneducated, living in abject poverty, and neglected by society. His theology was formed by the teachings found in scripture. “Religion that God our Father accepts as pure and faultless is this: to look after the widows and orphans in their distress and to keep oneself from being polluted by the world.” “Scripture compels The Salvation Army to serve others as a natural expression of loving God and being in right relationship with Him. Service to others is service to God.”³⁷ With limited resources or financial backing, the Salvation Army found a way to address what was lacking.

³⁵ Lee Knifton and Greig Inglis, “Poverty and Mental Health: Policy, Practice and Research Implications,” *BJPsych Bulletin* 44, no. 5 (2020): 193-196. doi:10.1192/bjb.2020.78

³⁶ Anne Gold, “Why Self-Esteem is Important for Mental Health,” National Alliance on Mental Illness, July 12, 2016, <https://www.nami.org/family-member-caregivers/why-self-esteem-is-important-for-mental-health/>.

³⁷ Bailey, “The Salvation Army and the United Nations,” 357.

The Booths continued to navigate complex relationships with other churches, seeking financial backing while disagreeing with the terms of partnership. He wanted to be accepted by reputable Christian organizations but faced mixed reactions.³⁸

By the mid-1880s the Salvation Army was already to be found ministering in many poor areas across the country. Other Christian Churches became concerned at the progress of their work. The Church of England reacted badly against their co-religionists, especially with what was seen as the uncontrollable emotionalism and lack of due reverence in its worship, professed and distinct anti-clericalism and absence of the sacraments. Many Anglicans were roundly critical of the Army, which they claimed tended towards emotionalism in religion.”³⁹

William Booth trusted that the necessary support would come, and much of the initial support came from people in the streets curious about their mission.

In 1878 and 1880, Booth organized leaders of the Salvation Army into ranks similar to regular military ranks: lieutenant, captain, major, lieutenant colonel, colonel, and commissioner. William Booth was its first officer in 1878 and was named general. Initially, army soldiers came from the streets where The Salvation Army ministered. Gamblers, thieves, drunkards, and those who were the first to convert to Christianity became the leaders. This is a testament to the army's effectiveness and demonstrates how those considered the least in society could serve in leadership roles. They effectively gained titles as they rose in rank based on their service. Those serving in leadership ranks were trained for their positions.

The Salvation Army has evolved over the years, and its foundational beliefs align with the teachings of the Old and New Testaments. The Salvation Army holds that (a) there is only one God; (b) there are three persons in the Godhead; (c) the divine and

³⁸ Murdoch, “The Salvation Army.”

³⁹ Huggins, *The Mob and The Mayor*, 10.

human natures are united in the person of Jesus Christ; (d) the first humans were created in innocence; (e) the Lord Jesus Christ made atonement for the world; (f) repentance toward God, faith in Christ, and regeneration by the Spirit are necessary for salvation; (g) we are justified by grace through faith in Christ; (h) continuing in a state of salvation depends on obedient faith in Christ; (i) believers have the privilege of being wholly sanctified; and (j) the soul is immortal. At the very heart of its principles and foundation, The Salvation Army operates as a Church.

The Salvation Army's current mission statement reflects this integrated approach to addressing physical and spiritual needs:

The Salvation Army, an international movement, is an evangelical part of the universal Christian Church. Its message is based on the Bible. Its ministry is motivated by the love of God. Its mission is to preach Jesus Christ's gospel and meet human needs in His name without discrimination.⁴⁰

If the established Church in England during the late 1880s had cared about the salvation and well-being of the working class, it likely would have been more open to The Salvation Army. Instead, the Church was motivated by its desire for control and a secular perspective that valued those with material wealth over the impoverished. Consequently, the established Church often strongly opposed the Salvationists. One could argue that the Salvation Army embodies an ecclesial mission and exemplifies ecclesial Christian action. Booth's "implicit and 'simple' ecclesiology, that the Army 'was divinely ordained...a renewal in the nineteenth century and twentieth century of the Church in the New Testament, the early Church, the Reformation Church, and the Wesleyan revival,' a manifestation 'of the historic Church from its inception in the New

⁴⁰ "What We Believe."

Testament...an integral part of that Church on earth.”⁴¹ This ignited his mission to imitate Christ in their approach to ministry, going out into the streets where the people were.

Booth began with a conviction and passion that inspired others to follow him. This is similar to Jesus’ encounter with a tax collector named Zacchaeus. Jesus declared to Zacchaeus, “Today salvation has come to this house, because this man, too, is a son of Abraham. For the Son of Man came to seek and to save the lost” (Luke 19:9-10). Specifically, in showing what it means to exhibit compassion and inclusion, recognizing the love of God through divine grace and how His grace can transform a world.

The Salvation Army, under Booth’s leadership and guided by Jesus’ example, emphasized love and belonging. Researcher Dorsey Jones described in the 1930s how “The Salvationists try as best they can to create an atmosphere of love so that the new convert feels as if he has found a new home. General Booth said, ‘I cannot understand how anyone can suppose for a moment that he is living a life acceptable to God unless he is striving with all his might to fulfill the divine command, “Thou shalt love thy neighbor as thyself.”’”⁴²

In 1879, sixteen-year-old Eliza Shirley, a member of a small working-class family, joined Booth’s Christian Mission in London as an evangelist. Later that year, her father, Amos, immigrated to the United States and found a job in Philadelphia as a foreman. He sent for his wife, Annie, and Eliza to join him, imploring Eliza to continue her spiritual work in America, where he saw a great need. Eliza, through prayer, felt

⁴¹ David W. Taylor, *Like a Mighty Army: The Salvation Army, the Church, and the Churches*, 1st ed. (Cambridge, UK: The Lutterworth Press, 2014), 101.

⁴² Jones, “Drumhead Salvationists,” 176.

compelled to go. Before her departure, she wrote to General Booth expressing her decision to join her father in America and to do the army work there. The response from Booth was not affirming,

The seventeen-year-old lieutenant received in reply “a very solemn communication setting before her her call, her vows, her precious work, the souls she had led to the Cross, the possibilities before her. Dare she for the sake of the love of father and mother give up?” It closed with the statement: “We are not prepared to commence operations so far away.... But if your letter is the final decision, if you must go, and if you should start a work, start it on the principles of the Salvation Army, and if it is a success, we may see our way clear to take it over.”⁴³

Eliza’s decision was firm, and she and her mother sailed for America in 1879. She was well-received at revival and camp meetings, reaching out to those who were neglected and unloved. Eliza was quite the trailblazer for the Salvation Army and sought to find a place for the birthplace of the Salvation Army in America with the help of her father, who provided the funds drawn from his wages to secure a building for their first meeting. When the building was finally suitable for people to attend, they put up posters with the words: “Blood and Fire. The Salvation Army.”⁴⁴ Only twelve people attended their first meeting on October 5, 1879.

In 1880, Booth’s mission moved to the United States, which “in the last two decades of the nineteenth century offered a fertile field to the Church of the Poor as the Salvation Army was sometimes called.”⁴⁵ Two interrelated factors led to an increased need among the poor in the United States. Protestant churches in America espoused the belief that the poor were a product of disease and idleness, paying the penalties for it.

⁴³ Wisbey, *Soldiers Without Swords*, 12.

⁴⁴ Wisbey, *Soldiers Without Swords*, 13.

⁴⁵ Wisbey, *Soldiers without Swords*, 80.

However, people experiencing poverty refused to accept this categorization and began not only to reject this view of their plight but also the Christianity that espoused it.

Also, during the 1880s, America was experiencing a period of increasing wealth, at least among certain segments of the population. The success of businesspeople who were also churchmen led them to lose sight of their Christian responsibility to practice their faith by attending to the needs of others. They viewed the poor as lazy and unwilling to take the necessary steps to improve their circumstances. Money became a motivator for the Church, and clergy succumbed to the flourishing world around them, even conducting business meetings during scheduled prayer meetings. They had grown numb to the plight of those experiencing poverty. Henry Ward Beecher, one of the nation's leading clergymen, illustrates the widespread attitude of the era toward labor problems.

Is the great working class oppressed?" he asked. "Yes, undoubtedly it is... God had intended the great to be great and the little to be little... I do not say that a dollar a day is enough to support a working man," he thundered. "But it is enough to support a man!... Not enough to support a man and five children if a man would insist on smoking and drinking beer.... But the man who cannot live on bread and water is not fit to live."⁴⁶

As with the Salvation Army in England, the Shirley's also experienced rejection. In an open-air meeting, they were pelted with rotting vegetables, stones, mud, refuse, and more.⁴⁷ Despite these obstacles, the Shirley family was relentless in their beliefs and determined to move forward, convinced that their actions were God's work and their responsibility. Eventually, Amos Shirley, who provided financial backing for the army, lost his job. Although he performed his duties adequately, a newspaper article about his

⁴⁶ Wisbey, *Soldiers Without Swords*, 11.

⁴⁷ Wisbey, *Soldiers Without Swords*.

involvement with the factory prompted his employer to ask him to choose between working at the factory or the army. He chose the army, dedicating his life to leading the mission. Over 15 years, they achieved significant growth for the Salvation Army in the United States. Booth's "success attracted many able evangelists who desired to join him in serving others of their class. Christian Missions like the original one in East London were soon opened in other cities in England, Wales, and Scotland."⁴⁸ The Salvation Army has continued to grow and is known worldwide for its continued work for over one hundred years.

Conclusion

The Salvation Army demonstrates what can be accomplished when a need is recognized and efforts are implemented to address that need. Booth saw human needs and realized that unless they were met, salvation would not be achieved. As he endeavored to save the souls of the lost, he found people struggling to survive daily. He also discovered that the Church, which he believed was focused on its ecclesial mission, directed attention primarily towards those with wealth. The individuals Booth preached to on the streets were adversely affected by their living conditions. Numerous factors contributed to these conditions, whether due to lack of work, skill, or education; poverty was widespread in England in the late 1800s. Although Booth may not have articulated it this way, we now recognize that poverty contributes to various health issues, particularly mental health. As researchers explain, "Mental health is a condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a

⁴⁸ McCallion, "The Salvation Army," 466.

satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment..”⁴⁹

Through observation, Booth initiated a program to improve the soul and, most importantly, the living conditions of the poor. Those neglected by the Church found a sense of belonging and purpose through the efforts of The Salvation Army. Over time, programs were developed to meet the needs of the poor, and those who benefited from these efforts became part of the army, demonstrating the value of relationships and illustrating that we, as Christians, have a responsibility to care for all people without distinction, fulfilling the commandment of loving your neighbor as yourself.

Everyone is our neighbor, and if one is neglected, we are not, therefore, fulfilling the ecclesial mission of the Church. William Booth’s actions serve as an inspiration for the Church today. His strategy began by recognizing a need not only with his eyes but also with his heart, listening and acting on what he could to address those needs. This is an example for the Church to follow by acknowledging suffering and doing what it can to provide support, either through direct action or by leading the hurting to proper resources. It is when low-level needs are met that the message of salvation can be preached and heard. Many of those whom the Salvation Army helped became part of the army, becoming soldiers. These soldiers (new converts) continue to fulfill the mission Booth initially set out to accomplish.

⁴⁹ Jose Bertolote, “The Roots of the Concept of Mental Health,” *World Psychiatry* 7, no. 2 (2008): 113-116.

Booth's drive sparked a global movement, demonstrating what can be achieved through deliberate effort and unrelenting faith. This does not diminish the significance of formal training. However, his journey began by observing and listening to understand what was necessary. Due to his faith, tenacity, love of God, and love for humankind, his efforts began and are now widespread around the world, addressing human needs while simultaneously fulfilling God's commandments. "Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind"; and, "Love your neighbor as yourself" (Luke 10:27b). He, along with his army of converts, came alongside the suffering and provided them with hope. The Church can do this by recognizing the distress of others, coming alongside them, and guiding them to appropriate resources.

Similar to Booth and the Salvation Army, one hopes the Church today will embody the Apostle Paul's admonition in light of the global mental health crisis: "You, my brothers and sisters, were called to be free. But do not use your freedom to indulge the flesh; rather, serve one another humbly in love. For the entire law is fulfilled in keeping this one command: 'Love your neighbor as yourself'" (Gal. 5:13-14).

William Booth's initial purpose was evangelism, specifically salvation. However, through this focus, he gained insight into what was most needed, which could also be achieved through evangelism—spreading the gospel not only through its teachings but also by living it out. "Do not merely listen to the word, and so deceive yourselves. Do what it says" (James 1:22). As Booth addressed the suffering of the people, he created an army trained to minister to the needs of others, working together to meet a growing demand within the streets of London and eventually worldwide.

When needs are met, it creates an environment where others may join and become part of it. Booth incorporated training and resources to provide direction and a foundation that would alleviate the suffering of others. He accomplished this by demonstrating it to those he encountered.

The mental health needs of our communities and the world are vast. With a deliberate focus, sincere care, and appropriate training, the church can play a crucial role in tackling the mental health crisis, serving as a frontline defense for guidance and support.

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

Introduction

The Church is a relational entity with an unchanging mission of love and compassion, expressed in various ways over time. In light of the current rise in mental health issues, the Church has a unique opportunity to serve as a facilitator, helping people understand what mental health is and how to recognize its signs. A solid theology of the role of the Church, or ecclesiology, offers insight into why and how the Church should respond to the global mental health crisis. I hypothesize that if ministry leaders are trained to recognize the signs of distress (i.e., anxiety and depression), they will be better equipped to show compassion and guide congregants to the help they need. This paper will seek to understand the Church's role relative to outreach, how the Church can be misunderstood, and how the Church is integral to Christianity, a faith that focuses on the teachings of Jesus Christ. Scripture attests to the Church as inherently relational, a community that is not individualistic but is focused on connecting each person for the good and growth of one another in Christian love and fellowship, or *koinonia* in Greek. (1 Cor. 12:12-27).¹

¹ All Bible verses taken from the New International Version.

The Church's mission is to serve and love others without discrimination. This is demonstrated through the actions of Jesus and His teachings. People join churches for various reasons, including shared beliefs, a sense of community, spiritual growth, and support during challenging times.

Doctrine and service unite to create the framework that supports Christ's teachings. The Bible shows the way to salvation, and this message is communicated through acts of service. Because of Christ's sacrifice on the cross, we receive the forgiveness of sins by the grace of God through faith. As the Apostle Paul explains in the book of Ephesians, "For it is by grace you have been saved, through faith—and this is not from yourselves, it is the gift of God—not by works, so that no one can boast. For we are God's handiwork, created in Christ Jesus to do good works, which God prepared in advance for us to do" (Eph. 2:8-10). This is the call for all of Christ's followers. Christians are called to labor, and that labor occurs beyond the confines of church walls, outside of physical comforts and isolation.

A solid understanding of ecclesiology (from the Greek translation, "an assembly, congregation, church; the Church, the whole body of Christian believers")—how the Church has evolved over the years and how scripture defines the Church and its responsibilities—is vital for carrying out all of Christ's commands without bias. The Church's approach to mental health is no exception: it can be a safe space to begin acquiring education about mental well-being and encourage conversations about mental health.

As we look at the Church, we must also understand that it is not merely a structure but is made up of individuals guided by the teachings of Christ. Jesus' teachings

emphasized compassion and care for those who were suffering. Mental health is no exception. The current focus on mental health underscores the necessity for mental health awareness and care. The isolation and limited social interaction recommended to ensure physical safety during COVID-19 only heightened the number of individuals needing such care. This increased awareness drew significant attention to mental health and the stigma surrounding it. The National Library of Medicine reports that “Far more than any other type of illness, mental disorders are subject to negative judgments and stigmatization.”² The Church has a chance to help eliminate this stigma, which requires a strong ecclesiology and a clear understanding of its role. The Church consists of individuals with physical, spiritual, mental, and emotional needs. This indicates a duty to provide comprehensive care for its congregants. As Barbara and Larry Dossey argue in *The American Journal of Nursing*, “the spirit is a dimension of holistic humanity, characterized by personal meanings that define one’s identity, vocation, life’s purpose, wellness, illness and relationships with others.”³

Existing healing ministries and sermons often fail to fully address mental health. The Church's response to mental health might include pastoral counseling, offering hospitality, supporting family members, implementing educational programs, and connecting congregants with resources. However, the Church is not limited to its walls; there are external initiatives to which the Church can actively contribute by providing care. Individuals experiencing mental health challenges within and outside the Church

² Wulf Rössler, “The Stigma of Mental Disorders: A Millennia-Long History of Social Exclusion and Prejudices,” *EMBO Reports* 17, no. 9 (2016): 1250-3. doi:10.15252/embr.201643041.

³ Barbara M. Dossey and Larry Dossey, “Body-Mind-Spirit: Attending to Holistic Care,” *The American Journal of Nursing* 98, no. 8 (1998): 35–38. <https://doi.org/10.2307/3471907>.

seek healing, guidance, understanding, forgiveness, and acceptance. Hesitations in addressing mental health could be overcome by revisiting the understanding of the role of the Church in the world. This paper is not intended to be prescriptive; rather, it aims to offer recommendations that address the holistic needs of the Church body, establishing a vision with clear goals. This vision could encompass holistic and wellness-focused ministries that educate congregants about mental health alongside culturally-based programs aimed at both adults and children, featuring easily accessible resources and materials to promote a comprehensive approach to healing and wellness.

The Church

What is the Church? The word “Church” (from the Greek “ekklesia”) first appears in the Bible and is found in Matthew’s gospel in Jesus’ discourse with his disciples.

When Jesus came to the region of Caesarea Philippi, he asked his disciples, “Who do people say the Son of Man is?” They replied, “Some say John the Baptist; others say Elijah; and still others, Jeremiah or one of the prophets.” “But what about you?” he asked. “Who do you say I am?” Simon Peter answered, “You are the Messiah, the Son of the living God.” Jesus replied, “Blessed are you, Simon son of Jonah, for this was not revealed to you by flesh and blood, but by my Father in heaven. And I tell you that you are Peter, and on this rock I will build my Church, and the gates of Hades will not overcome it (Matt. 16:13-18).

This text is wrought with varying opinions and commentary on Jesus’ reference to Peter as a “rock” on which He will build His Church. Translated from Greek, Peter’s name is Petros, which means rock or stone; hence, “You are petra, a stone, and on this rock, I will build my Church.” Peter’s name metaphorically stands for strength and stability, and he was the first disciple who spoke for Christ when the Church was formed. In Acts 2, Peter preaches the first sermon and 3,000 people come to faith in Christ in a single day (Acts 2:14-42).

Dyron D. Daugherty calls attention to the array of images the New Testament uses to depict the church:

[A]rchitecture, family, body images (one body, many parts), a flock of sheep, a military unit, a married couple (Jesus is groom, people the bride), a school of students with Jesus as teacher, a kingdom. However, at the root of all of these metaphors is a Greek word that has been studied intensely for centuries: *ecclesia*—the word translated “church.” *Ecclesia* has become a Christian word, but it was common in the Greek language before the New Testament era. In its most basic sense it refers to a public assembly that has been called out by a herald, from the words *ek* (out) and *kalein* (to call). The word was used by the Greek translators of the Hebrew Bible to refer to Israel’s gathering before the Lord (see Acts 7:38).⁴

The term “Church” is not understood universally, especially within Protestantism.

The Church can have multiple meanings and is diverse, consisting of various denominational groups and practices. Graf states, “But there is neither a Protestant ‘world church’ comparable to Roman Catholic centralism nor any other kind of globally organized institution that might be in a position to unite the factual diversity of Protestant churches and groups.”⁵

To understand the Church, one must grasp the meaning of being a Christian. They are not exclusive of each other. In his book “Introducing Christian Theologies II,” Victor I. Ezigbo outlines various aspects of Christian identity, covering everything from the purpose of Christian theology to the characteristics of a Christian life.⁶ Ezigbo suggests that the actions and teachings of Jesus Christ, through acts of service as a community of

⁴ Dyron B. Daugherty, *To Whom Does Christianity Belong?: Critical Issues in World Christianity* (Minneapolis, MN: 1517 Media, 2015), 44.

⁵ Friedrich Wilhelm Graf and Alex Skinner, “Protestantism,” In *Secularization and the World Religions*, ed by Hans Joas and Klaus Wiegandt, 1st ed., 46–76 (Liverpool, UK: Liverpool University Press, 2009), 46.

⁶ Victor Ezigbo, *Introducing Christian Theologies II: Voices from Global Christian Communities - Volume 2*, 1st ed. (London, UK: The Lutterworth Press, 2015), 308.

faith, identify those who follow Him. Similarly, German theologian Dietrich Bonhoeffer writes in *Life Together*,

Christ is proclaimed present in this community as the Word, gracing Christians to go beyond the superficial, often self-centered relationships of their everyday associations and to move toward a more intimate sense of what it means to be Christ to others, and to love others as Christ has loved them.⁷

This encourages individuals to move beyond the Church (i.e., the structure) and their personal comforts to cultivate relationships with others. Both Ezigbo and Bonhoeffer agree that Christian identity is realized in being Christ to others. Being Christ to others is an essential characteristic for Christians.

Scripture defines the Church as “the body of Christ,” which consists of many parts, with each being a part of one body (1 Cor. 12:12–20). The English word “church” originates from the Greek terms *kyriakon* or *kyriaka*, which meaning “that which belongs to the Lord.”⁸ Established by Jesus, the Church is not merely a group of scattered individual followers; it is a place where people come to experience a sense of belonging and identity, demonstrating the love of Christ to everyone. It serves as a community rich in love and support, where individuals collaborate for the common good. Without Christ, there is no Church. Wilhelm Pauck argues that the Church and faith work together, and neither exists without the other “To the Christian faith, to distinguish between the faith and the “Church” is a sign of Christian weakness, for actually it is impossible to be a Christian believer apart from the social reality of the Church.”⁹ The Church represents

⁷ Geoffrey B Kelly, *Reading Bonhoeffer: A Guide to His Spiritual Classics and Selected Writings on Peace*, 1st ed., (London, UK: The Lutterworth Press, 2008), viii.

⁸ Wilhelm Pauck, “The Idea of the Church in Christian History,” *Church History* 21, no. 3 (1952): 193.

⁹ Pauck, “The Idea of the Church,” 192.

more than just a philosophical construct. It serves as the foundation of faith in Jesus Christ. Without Christ, the Church is non-existent.¹⁰ Giving further evidence of the significance of the Church to Christianity, Pauck notes that “It is customary to describe and interpret the history of Christianity as Church history.”¹¹

The Church has faced controversies, challenges, opposition, and struggles for centuries. Diverse interpretations of scripture and authoritarian leadership have contributed to these varying explanations. Early tradition traces the Church's foundation in Rome to St. Peter and St. Paul, with St. Peter taking precedence over his brother St. Paul.¹² Although the origins of Christianity in Rome are still unclear, we do have St. Paul's Epistle written to the Romans in 58 A.D., before either he or St. Peter visited.¹³ While uncertainties persist, what is clear is that “Christianity first found its way into Rome through the Jewish community which existed there in the first century.”¹⁴

The Church can be defined as an institution, a society of organized believers founded on their religious faith in Christ. Therefore, when we discuss the Church, we are discussing what it means to be a Christian. “Mark Dyer observed that ‘About every 500 years the empowered structures of institutionalized Christianity, has become an intolerable carapace that must be shattered in order that renewal and new growth may

¹⁰ Pauck, “The Idea of the Church,” 197.

¹¹ Pauck, “The Idea of the Church,” 191.

¹² James Henry Hingston, “The Origin of Christianity in Rome,” *The Irish Church Quarterly* 8, no. 31 (1915): 200.

¹³ Hingston, “The Origin of Christianity in Rome,” 200.

¹⁴ Hingston, “The Origin of Christianity in Rome,” 200.

occur.”¹⁵ From the fall of the Roman Empire, which marked the first schism, to the 16th century, when Martin Luther produced his 95 theses in Wittenberg, the Church has undergone change.

The Church has evolved over centuries, with pivotal moments shaping ecclesiastical rituals and practices. It continues to experience growth and change.¹⁶ The Church today is undergoing a reformation with new practices. Jerry Pillay, from the Faculty of Theology at the University of Pretoria, South Africa asserts:

It is important to note that the radical change in the 16th century was largely theological. The Protestant Reformation of the sixteenth century had a significant impact on the current reformation, as seen in the Emerging Church and Fresh Expressions movements, is not so much a reformation of *faith* (the essential theological principles of the Reformation) but a reformation of *practice* (Wagner, 1982: 36). A major difference is that the 16th century reformation came in reaction to a corrupt and apostate church. The current reformation is a reaction to the irrelevance of the church in relation to the Gospel and its mission.¹⁷

Martin Luther was not the only individual who significantly impacted the sixteenth-century Reformation; John Calvin also played a crucial role. Although their ecclesiologies differed, they agreed on many doctrines, including their rejection of the power of papal authority and indulgences. They both believed the Church’s focus should be on the internal Church and the Holy Spirit operating within believers, rather than on external powers—such as the Catholic Church—which they considered to be abusive.

The more closely the religious history of the sixteenth century is investigated the more evident does it become that there were two reformations. One was a reforming of institutions, whether it involved the assertion of royal sovereignty over the church or the construction and revitalization of existing ecclesiastical organization. The other reformation was a genuine reformation, a reconsideration

¹⁵ Jerry Pillay, “COVID-19 Shows the Need to Make Church More Flexible,” *Transformation* 37, no. 4 (2020): 266. <https://www.jstor.org/stable/27081814>.

¹⁶ Pillay, “COVID-19 Shows the Need,” 266.

¹⁷ Pillay, “COVID-19 Shows the Need,” 267.

of the nature of Christianity. The first kind of reformation was an external phenomenon; the latter reformation looked inward in trying to discover how corrupt and impotent humanity could be made righteous by faith.¹⁸

These two reformations overlapped, and Luther became a spokesman for both.¹⁹ “Both sixteenth-century reformations had a common starting-point in widespread disaffection with the ossified and decadent late medieval church.”²⁰ Monarchy, hierarchy, and aristocracy were viewed as corrupt and sources of misery. The only stable points remaining were elements not regarded as rotten or absurd, such as the personal experiences of the reformers and a loving God.²¹

The ecclesiology of German theologian Martin Luther centered on God’s word. He suggests that the church “presents itself as an identifiable number of human beings whose unity has an institutional shape, who profess one common faith and do certain things together.”²² Although Luther did not have a systematic ecclesiology, his writings convey theological coherence.²³ His definition of the Church is not the structure but those whose common beliefs make them one, encouraging each other in a community where people from various backgrounds and occupations come together to socialize and support one another. God's word is where you will find the Church, whether it is conveyed through preaching or teaching. Luther believed that “depression was in some regards a

¹⁸ Norman Cantor, “A Prolegomenon to Reformation,” *Political Science Quarterly* 81, no. 1 (March 1966): 69.

¹⁹ Cantor, “Prolegomenon,” 70.

²⁰ Cantor, “Prolegomenon,” 71.

²¹ Cantor, “Prolegomenon,” 74.

²² Nelson H. Minnich and Michael Root, eds., *Martin Luther and the Shaping of the Catholic Tradition: Proceedings of the International Conference Held in Washington, DC May 30 to June 1, 2017* (Washington, DC: Catholic University of America Press, 2021), 226.

²³ Minnich and Root, *Martin Luther*, 223.

universal occurrence afflicting even the people of God. This type of attitude often saves sufferers from unnecessary guilt and shame.”²⁴ Luther believed God works through other believers.²⁵

Luther advised one severely depressed person, “cease relying on and pursuing your own thoughts. Listen to other people who are not subject to this temptation. Give the closest attention to what we say, and let our words penetrate to your heart. Thus God will strengthen and comfort you by means of our words.” “Believers also serve a second function. Their company pulls depressed persons away from dangerous solitude. In Luther’s view, solitude fosters depression. Therefore, he counseled sufferers to seek the company of believers not caught in the web of depression. He knew that godly company serves several purposes: it affords an opportunity to receive a different and brighter perspective on life; it serves as a precaution against suicide; and it provides an opportunity for good, clean, wholesome fun. Luther repeatedly recommended playing games, joking, jesting and enjoying other forms of merriment.”²⁶

Martin Luther’s own example of suffering from depression provides insight into how the church can be influential in providing support and guidance, “Luther himself probably provides the supreme example of recovery from depression correlated with a modification of religious attitudes toward greater self-tolerance and less emphasis on sinfulness.” His rejection of the system of confession and making amends of guilt, brought him great psychological pain. It was his focus on faith and the mercy of God that brought him comfort.²⁷

John Calvin, another influential sixteenth-century Reformer, initially pursued a career in law, but his interests and passions directed him toward humanism. This

²⁴ Allan Adams, “Martin Luther on Depression,” Opinion, The Aquila Report, May 17, 2016, <https://theaquilareport.com/martin-luther-on-depression/>.

²⁵ Adams, “Martin Luther on Depression.”

²⁶ Adams, “Martin Luther on Depression.”

²⁷ N. J. C. Andreasen, “The Role of Religion in Depression,” *Journal of Religion and Health* 11, no. 2 (1972): 153–66. <http://www.jstor.org/stable/27505117>.

philosophy focuses on human interests and emphasizes self-realization over mere manifestation of the supernatural.

The movement called humanism is perhaps best understood as a reform of education by reorienting pedagogy from textbooks to primary sources and from proof to persuasion. Instead of learning what all the great theologians had said about the Bible, Christian humanists wanted to read the Bible itself in its original languages; instead of attempting to prove truth by dialectic, they wanted to persuade people of truth in a way that would change their lives.²⁸

Calvin's emphasis on the humanist study of law and language became part of an evangelical movement within the French church.²⁹

Elsie McKee writes:

In the early 1530s Calvin was involved with reformers within the Church who were expressing Christian teaching in untraditional ways. Late medieval Western Christianity was a faith alive with many currents of activity; clergy and increasing numbers of laity were seeking reform of abuses and especially a deepening of piety.³⁰

Information about Calvin's conversion is scant due to his widely perceived reluctance to discuss himself. Despite this lack of information, what is clear is his involvement with the reformers in the early sixteenth century.³¹ Calvin believed that the Church order is found in the New Testament alone: there are two presbyters, the pastor, and elders, who serve as the organ of the Church's oversight in matters of faith and practice, demonstrating and representing the essence of Christianity. Elsie McKee, Archibald Professor of

²⁸ Elsie McKee, "(Re)Introducing Pastor John Calvin," *The Journal of Presbyterian History* (1997-) 87, no. 2 (2009): 53.

²⁹ McKee, "(Re)Introducing Pastor John Calvin," 53.

³⁰ McKee, "(Re)Introducing Pastor John Calvin," 54.

³¹ McKee, "(Re)Introducing Pastor John Calvin," 54.

Reformation Studies and History of Worship at Princeton explore Calvin's perspective on church order.

"It is clear that there were no Christian rulers in the days of the apostolic (and model) church, they cannot be necessary or even proper for a rightly ordered church. Calvin was convinced he must insist on the autonomy of the Church with regard to oversight of Christian life and ministry to the poor, as well as preaching and teaching, although in a Christian society, ecclesiastical and civil authorities should cooperate, and one might elect magistrates as elders or deacons. These "lay ecclesiastical" ministers and an ecclesiastical polity which can stand alone or cooperate with civil powers are in fact two of Calvin's distinctive contributions to the doctrine of the Church."³²

It was Luther's criticism of the Roman Catholic Church that helped spark the Reformation. This criticism emerged when he read in scripture, "For in the gospel the righteousness of God is revealed a righteousness that is by faith from first to last, just as it is written: 'The righteous will live by faith'" (Rom. 1:17). In contrast, Calvin's emphasis was on sanctification, declaring or becoming holy. Although Luther and Calvin did not fully agree on many of their doctrines, they did concur in rejecting the authority of the pope and the practice of indulgences.

Long before Luther or Calvin, there was Augustine of Hippo, a theologian and philosopher of the fifth century. A Doctor of the Latin Church, according to Author and Theologian Wilhelm Pauck, he had "some of the most robust thinking on the nature of the Church, present[ing] a theology of the Church unrivaled among the ancient theologians both by its exhaustiveness and suggestiveness."³³ "Augustine stressed the nature of the church as a social community. He called it a 'congregation and society of

³² McKee, "(Re)Introducing Pastor John Calvin," 59.

³³ Pauck, "The Idea of the Church," 198.

men in which brother love is at work.”³⁴ The Church can be described as a community of love for all. “The institutional church is thus viewed as the historical manifestation of the eternal order of love.”³⁵

Christian love and responsibility can only be fully understood when taught effectively. Pope John XXIII’s address to the Second Vatican Council aimed to tackle this issue. In a subsequent analysis of this address, Joseph Veale explained,

It was at the heart of Pope John’s concern for the world that the countenance of Christ in his Church might be revealed more effectively to all men of goodwill. The human means we use in teaching Christ and his message must change from age to age. It is necessary, then, that we re-examine the means we use to teach Christianity within the Church.³⁶

How we teach Christ may change, but the message of love remains constant. Through the teaching of Christ, we express His love in various ways, while the Holy Spirit empowers us to reveal His love through teaching and preaching. During the announcement of the Second Vatican Council, Pope John XXIII asked people to pray for a new Pentecost.³⁷ He was praying for the same fire exhibited at Pentecost to be poured down on the Church:

When the day of Pentecost came, they were all together in one place. Suddenly a sound like the blowing of a violent wind came from heaven and filled the whole house where they were sitting. They saw what seemed to be tongues of fire that separated and came to rest on each of them. All of them were filled with the Holy Spirit and began to speak in other tongues as the Spirit enabled them (Acts 2:1-4).

Pope John XXIII’s prayer sought the same zeal at Pentecost to inhabit the people. It aimed for the kind of power that inspired awe and amazement while also instilling in

³⁴ Pauck, “The Idea of the Church,” 199.

³⁵ Pauck, “The Idea of the Church,” 201.

³⁶ Joseph Veale, “Christian Responsibility,” *Studies: An Irish Quarterly Review* 53, no. 210 (1964): 118. <http://www.jstor.org/stable/30088824>.

³⁷ Helen Greal, “What Is the Spirit Saying to the Churches?” *The Furrow* 65, no. 2 (2014): 91. <http://www.jstor.org/stable/24635904>.

them the desire to perform the works that Jesus did through love and selflessness.

German theologian Dietrich Bonhoeffer echoes similar sentiments about human responsibility in caring for others, which has not changed since the establishment of the Church. Dietrich Bonhoeffer writes:

What church “is” can only be said if we say both what it is from the viewpoint of human beings and what it is from the standpoint of God. Both belong inseparably together. It is in this dual nature that it exists. Thus we are talking about not what the church should be and that means, in other words, what we should make of the church today, but rather what it [is] when it “is.” This is the essential point.”³⁸

Bonhoeffer makes significant points when describing the Church. He indicates that it is God who qualifies the Church by His entry into it and that through His mercy, He has prevented humankind from being consumed by the evils of the world. The Church is a unified institution preserved for “Christian piety and morals, serving public life and order. It is a part of the world that is lost, vain, godless, and evil. The Church is for the people, and there is only one Church in the world. Church is the living Christ.”³⁹

Bonhoeffer also offers a scathing critique on what the church has become:

Church is a union of religiously inclined, interested people who curiously enjoy expressing their religiosity in this form of church. Today they generally belong to a social class that is neither particularly spiritually lively nor a particularly future-oriented creative force, but rather offers a certain contentment with their own achievements as its most pronounced characteristic. Here the atmosphere is relatively thin and the horizons restricted. Not a lot seems to take place. More “happens” in the cinema; it is more interesting.⁴⁰

³⁸ Dietrich Bonhoeffer, *Berlin: 1932 - 1933: Dietrich Bonhoeffer Works, Volume 12*, edited by Larry L. Rasmussen, translated by Isabel Best, David Higgins, and Douglas W. Stott (Minneapolis, MN: 1517 Media, 2009), 262.

³⁹ Bonhoeffer, *Berlin: 1932-1933*, 263.

⁴⁰ Bonhoeffer, *Berlin: 1932-1933*, 263.

This stands in stark contrast to what the Church ought to be. The church is a fellowship, a community of saints connected to one another, “giving themselves, accepting responsibility because it was placed on them by God; a community through sacrifice, prayer, and forgiveness, shattering the chains of isolation, the reality of being together and for one another, love, fraternity. All that from God.”⁴¹ This kind of fellowship requires the aid of the Holy Spirit.

The Church’s shortcomings do not alter what God intended it to be: a community of believers, foreigners, and strangers collaborating as members of God’s household. As scripture proclaims:

Consequently, you are no longer foreigners and strangers, but fellow citizens with God’s people and also members of his household, built on the foundation of the apostles and prophets, with Christ Jesus himself as the chief cornerstone. In him the whole building is joined together and rises to become a holy temple in the Lord. And in him you too are being built together to become a dwelling in which God lives by his Spirit (Eph 2:19-22).

It’s impossible to discuss the Church without addressing the Holy Spirit. The Holy Spirit equips the Church, providing it with what it needs to do the works of Christ:

So Christ himself gave the apostles, the prophets, the evangelists, the pastors and teachers, to equip his people for works of service, so that the body of Christ may be built up until we all reach unity in the faith and in the knowledge of the Son of God and become mature, attaining to the whole measure of the fullness of Christ (Eph. 4:11-13).

Helen Grealy, a Cenacle Sister asks, “What is the Spirit Saying to the Churches?” She espouses, “My own strong sense is that God’s Spirit is calling for a radical change in the

⁴¹ Bonhoeffer, *Berlin: 1932-1933*, 263.

Catholic Church. Many deeply committed Christians are calling for reform in our church, especially regarding its leadership.”⁴²

It is God who calls and purposes the Church. According to His will, individuals are invited to share in His message of salvation, awakening an evil world to a reality where people live for Him. Living for Him involves following the principles outlined in His word through accurate biblical preaching and teaching. Unfortunately, over the years, the Church has declined in effectiveness, as evidenced by decreasing attendance in the Western world. A recent Gallup poll reported:

Two decades ago, an average of 42% of U.S. adults attended religious services every week or nearly every week. A decade ago, the figure fell to 38%, and it is currently at 30%. This decline is largely driven by the increase in the percentage of Americans with no religious affiliation—9% in 2000-2003 versus 21% in 2021-2023—almost all of whom do not attend services regularly. Still, most religious groups have also seen a decline in regular attendance at religious services over the past two decades.⁴³

This report raises the question: what has happened to the Church that God established for the world that has been called to Him?

The Church and its members are called to acts of service as a community, collaborating and working together: the weak, the strong, and the capable uniting to learn, grow, and challenge one another. Challenges can arise for those who seek only to gather followers for their own agenda, failing to recognize the potential in others. Such a church community stands in stark contrast to embodying Christ in the world and leaves little room for gaining additional perspectives, making it easy to overlook, ignore, or sidestep

⁴² Greal, “What Is the Spirit Saying to the Churches?” 91-92.

⁴³ Jeffrey M. Jones, “Church Attendance Has Declined in Most U.S. Religious Groups,” Gallup Poll, last updated March 25, 2024, <https://news.gallup.com/poll/642548/church-attendance-declined-religious-groups.aspx>.

the truth. People may concentrate on doctrinal practices rather than providing service to others. Doctrinal practices are crucial for teaching truths and establishing the foundation of the Church. However, doctrine should never overshadow duty. Instead, doctrine and service can work together in harmony. In a healthy church community, congregants support one another, even across lines of disagreement.

It is due to what Christ accomplished for everyone on the cross that we experience the forgiveness of sins by the grace of God through faith. As Paul explains in the book of Ephesians, “For it is by grace you have been saved, through faith—and this is not from yourselves, it is the gift of God—not by works, so that no one can boast. For we are God’s handiwork, created in Christ Jesus to do good works, which God prepared in advance for us to do” (Eph. 2:8-10). Jesus paid our sin debt and in response, we are called to do good works. Doing good work requires effort aligned with Christian teaching. In the past, this meant attending services and being ready to share, pray, and comfort those in need. While this remains true, it now also demands initiative and intentional action. It involves understanding the full role of the Church, why Jesus established it, and how the Church influences people through faith and the practice of righteousness, by following God’s law and expressing unconditional love. It entails obeying the Great Commandment to, “Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind”; and, ‘Love your neighbor as yourself’” (Luke 10:27).

Conclusion

The pandemic of 2020 highlighted the increase in mental health issues. During that time, many everyday activities came to a halt. Without social connections,

individuals struggled to cope, uncertain about how long the isolation and loneliness would last. Churches closed their doors, and the only venue that could bring people together faced the same imposed restrictions. As a result, congregants not only dealt with physical limitations but also experienced adverse effects on their emotional, spiritual, and mental well-being.

The study of Ecclesiology provides a framework for today's Church. It explains the role of the Church as God intended, along with the teachings of Christ that guide what His followers are called to do. Just as the Protestant Reformation significantly impacted the church and its practices, we are witnessing a new reformation in movements like the "Emerging Church" and "Fresh Expressions." Today, the Church needs reform based not on the theological principles of faith but on practice.

The event that highlighted the need for mental health support also signals a time for reforming previous methods of conducting church. It is essential to develop new ways to reach out to those in pain, helping individuals emerge from isolation while continuing to operate based on Christ's teachings. God has not changed, nor has Christ, and the Church, as Jesus intended it, should not change, because the power of the Holy Spirit, which dwells in all who confess faith in Christ, also remains the same.

The Church is made up of human beings. While this paper does not aim to understand the human mind, it seeks to explore how the Church can provide comfort grounded in love and compassion to those suffering from distress. We are created in God's image, endowed with God's Spirit, the same Spirit poured out at Pentecost. This reflects the moment of creation when God breathed into humankind a part of Himself. (Gen. 2:7).

Technology has expanded the Church's reach to individuals who may have previously lacked access. However, technology cannot replace the necessity of human interaction, and not everyone has access to it. We consist of mind, body, and spirit, and each aspect requires nurturing. The Church is where that nurturing can begin.

The Church can provide a framework for identifying congregants' needs and determining how to address those needs within that framework. Understanding how congregants perceive mental health programs can help clarify how effective the Church can be in reducing stigma by creating tools, methods, and programs that demonstrate love for one's neighbor amidst the challenges of mental health struggles. A significant consideration is a congregant's willingness to engage in such an initiative. Another consideration is the leaders' role in supporting mental health programs. Both aspects could be influenced by education on the importance of mental health and how faith can support it.

Churches can provide a supportive emotional and social environment, and they are often less intimidating for churchgoers than seeking help from someone unfamiliar. The social atmosphere, shared belief system, and trusting relationships within a church offer pastors and church leaders a unique opportunity to positively influence the lives of those facing mental health challenges. Churches serve as safe places where people voluntarily gather, supporting diverse groups and populations. This helps individuals realize that they are not alone and that assistance is available. Not everyone has the resources to access formal mental health care, but the Church—Christ's Church—welcomes everyone without discrimination.

More individuals may find the guidance they need if churches create programs, systems, and methods to support their congregants' mental health. While these programs may not provide a complete solution to the global mental health crisis, they can have a meaningful impact by building healthy relationships and a sense of belonging that offers hope and resources to those in distress. By destigmatizing mental health, fostering a safe community, and directing people to resources, churches can strive to fulfill their purpose of loving others and expressing Christ's compassion: not a reformation of faith but a reformation of practice.

CHAPTER FIVE

INTERDISCIPLINARY FOUNDATIONS

Introduction

The significant increase in individuals experiencing mental health conditions is greatly affecting the quality of life worldwide. Two key contributors to this phenomenon are loneliness and isolation. Evidence shows the substantial impact of social isolation and loneliness on physical health, including an increased risk of premature death. The World Health Organization has drawn attention to the global rise in declining mental health, declaring:

Mental health disorders have reached epidemic proportions worldwide. In the United States (U.S.), the burgeoning costs of mental disorders constitute the most costly medical condition, amounting to 201 billion U.S. dollars annually, which surpasses heart conditions (147 billion U.S. dollars), trauma (143 billion U.S. dollars) and cancer (122 billion U.S. dollars).¹

These numbers suggest that mental health, previously viewed as concerning, now presents an even greater challenge as a result of COVID-19.²

¹ World Health Organization, *Depression and Other Common Mental Disorders: Global Health Estimates* (Geneva, Switzerland: World Health Organization, 2017).

² Jean M. Twenge and Thomas E Joiner, “Mental Distress Among U.S. Adults During the COVID-19 Pandemic,” *Journal of Clinical Psychology* 76, no. 12 (2020): 2170-2182. doi:10.1002/jclp.23064.

It is not easy to attribute this increase to any single event or circumstance due to the many influences on it consider.³ However, the risks of isolation and loneliness are significant and must be addressed. Some health risks associated with social isolation have been compared to those of smoking and obesity.⁴ As mentioned in an article from the journal *Psychosomatic Medicine*, “Individuals who lack social connections or report frequent feelings of loneliness tend to suffer higher rates of morbidity and mortality.”⁵ The lack of social identity has been linked to stress, anxiety, and depression, each contributing to poor mental health. The Center for Addiction and Mental Health reports:

When stress becomes overwhelming and prolonged, the risks for mental health problems and medical problems increase. Long-term stress increases the risk of mental health problems such as anxiety and depression, substance use problems, sleep problems, pain, and bodily complaints such as muscle tension.⁶

In contrast, maintaining healthy social connections can influence the development of effective coping strategies for addressing mental health.

Many researchers and psychologists have explored the intricate relationship between social connection, identity, and mental health. Peter Burke, in his article “Identity Processes and Social Stress,” explains that “Thirty years ago, in *Identity and Anxiety*, Stein, Vidich and White (1960) expressed the concern that the advent of a mass

³ Erin York Cornwell and Linda J. Waite. “Social Disconnectedness, Perceived Isolation, and Health among Older Adults,” *Journal of Health and Social Behavior* 50, no. 1 (2009): 31.

⁴ James S. House, “Social Isolation Kills, But How and Why?” *Psychosomatic Medicine* 63, no. 2 (March 2001): 273-74.

⁵ Beverly H. Brummett et al., “Characteristics of Socially Isolated Patients with Coronary Artery Disease Who are at Elevated Risk for Mortality,” *Psychosomatic Medicine* 63, no.2 (March 2021): 267-272.

⁶ “Stress,” Mental Illness and Addiction Index, Health Info, Centre for Addiction and Mental Health, <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/stress>.

society would lead to a “loss of identity” and hence to widespread anxiety or stress.”⁷

This may help explain the current decline in mental health. In the 1970s, psychologist Henri Tajfel and his doctoral student John Turner developed social identity theory (SIT), which asserts that people derive a portion of their identity from membership in social groups.⁸ Social identity entails how one sees oneself within a group setting and how groups influence personal behavior. Many factors influence our identities and the connections we form, including ethnicity, generation, location, gender, nationality, morals, beliefs, age, and social class. The complexities of individual identity and the internal and external connections that influence it socially offer insight into how individuals interact with themselves and integrate into society.

Social identity theory (SIT) offers insights into how establishing healthy external relationships can reduce symptoms related to mental health. In the context of my thesis, SIT may elucidate the church's role in the mental health crisis and provide fundamental principles for the church to adopt. The church acts as a social setting that can foster social identity. This paper will explore SIT to understand how belonging to a community, particularly a church community, can alleviate loneliness and isolation while promoting better mental health.

⁷ Peter J. Burke, “Identity Processes and Social Stress,” *American Sociological Review* 56, no. 6 (December 1991): 836.

⁸ Saul McLeod, “Social Identity Theory in Psychology (Tajfel and Turner, 1979),” *Social Science, Simply Psychology*, last updated October 5, 2023, <https://www.simplypsychology.org/social-identity-theory.html>.

Interdisciplinary Theory

Henri Tajfel, a Polish Jew, served in the French army during World War II. After being captured by the Germans, he concealed his Jewish heritage which enabled him to avoid being placed in a prisoner of war camp. Following his military service, none of his family or friends were alive. His wartime experiences shaped his interest in people and, more specifically, in prejudice, group identity, and the Holocaust. Kim Mills, senior director of strategic external communications and public affairs for the American Psychological Association, states, “He understood that the Holocaust was not a product of psychology but of the way in which psychological processes operate within a given social and political context.”⁹

Researchers Kati Kish Bar-On and Ehud Lamm summarize Tajfel’s understanding of social identity theory:

Tajfel defined social identity as ‘that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership.’ He argued that when people voluntarily categorize themselves as belonging to a specific group, they perceive themselves differently, and their self-conception changes.¹⁰

Tajfel was careful to assert that SIT should not be viewed in reductionist or simpler terms. He proposed that groups are essential for esteem and pride, providing a sense of belonging, purpose, self-worth, and identity.¹¹

⁹ Kim Mills, “Speaking of Psychology: How the Need to Belong Drives Human Behavior with Geoffrey L. Cohen, PhD,” Episode 206, <https://www.apa.org/news/podcasts/speaking-of-psychology/human-behavior>.

¹⁰ Kati Bar-On Kish and Ehud Lamm, “The Interplay of Social Identity and Norm Psychology in the Evolution of Human Groups,” *Philosophical Transactions of the Royal Society of London Series B, Biological Sciences* 378, no. 1872 (March 2023): 20210412. doi:10.1098/rstb.2021.0412.

¹¹ McLeod, “Social Identity Theory.”

According to SIT, personal innate characteristics, criteria, and needs typically drive an individual's desire to join a group. When a person joins a group, they seek others with similar ideologies. Individuals who do not align with the group due to a lack of identification or similarities are considered the out-group. The in-group is a positive collective with distinctive qualities that benefit its members. However, the out-group is perceived negatively by the in-group. This does not imply that the out-group inherently lacks redeeming qualities; rather, it conflicts with the beliefs and opinions of the in-group.

This is evident in U.S. politics across party lines. According to the Pew Research Center, "Republicans and Democrats prioritize family, but they differ over other sources of meaning in life."¹² The party a person agrees with becomes that person's in-group. In the case of someone who psychologically aligns with Republicans and disagrees with Democrats, Republicans would be their in-group. If a person agrees with Democrats and opposes Republicans, then Republicans become their out-group. This example illustrates how both political parties view family, as they share certain aspects. Still, their differences generate negative perceptions of the opposing group, creating bias, prejudice, and stereotyping against the out-group. Labeling out-groups as unfavorable devalues them and fails to acknowledge the truths that may exist within their perspectives.

Social identity theory posits that, in the context of solutions to the mental health crisis, being part of an in-group with a shared ideology can provide a sense of meaning

¹² Laura Silver and Patrick Van Kessel, "Both Republicans and Democrats Prioritize Family, but They Differ Over Other Sources of Meaning in Life," Short Reads, Pew Research Center, last updated November 22, 2021, <https://www.pewresearch.org/short-reads/2021/11/22/both-republicans-and-democrats-prioritize-family-but-they-differ-over-other-sources-of-meaning-in-life/>.

and, therefore, promote mental well-being. Significantly, “Group identification reduces uncertainty by prescribing who individuals are, how they should behave, and how others may react to them.”¹³ However, belonging to an in-group also involves cultivating a negative view of the out-group. This may manifest as a lack of openness to differing perspectives and opinions.

According to SIT, “social identity has three major components: categorization, identification, and comparison.”¹⁴ In-group and out-group representation is one of the three components of categorization. Identification involves both individual and social identity, and the positive aspects of social identity must not overshadow individual identity. According to Hogg and Terry’s analysis of identity and categorization in organizations, “Social identity rests on intergroup social comparisons that seek to confirm or to establish ingroup-favoring evaluative distinctiveness between ingroup and outgroup, motivated by an underlying need for self esteem.”¹⁵ This underscores the significance of understanding individual identity to grasp how their uniqueness impacts others, particularly in their relationships. Erikson (1975) defined identity as a subjective sense of personal sameness, arising from certain aspects of the self, such as appearance, temperament, and abilities, combined with chosen roles, occupations, and relationships.¹⁶ A person who does not identify with a specific social group is unlikely to join that group.

¹³ Steven Pirutinsky and Alfred F. Mancuso, “Who Are We? Social Identity and Psychological Well-Being,” *Graduate Student Journal of Psychology* 13 (January 2011): 39.

¹⁴ Yan Chen and Sherry Xin Li, “Group Identity and Social Preferences,” *The American Economic Review* 99, no. 1 (March 2009): 431. <http://www.jstor.org/stable/29730190>.

¹⁵ Michael A. Hogg and Deborah J. Terry, “Social Identity and Self-Categorization Processes in Organizational Contexts,” *The Academy of Management Review* 25, no. 1 (January 2000): 122. <https://doi.org/10.2307/259266>.

¹⁶ Pirutinsky and Mancuso, “Who Are We?”

Being part of a group offers significant benefits; however, relying solely on groupthink or in-group dynamics can be limiting, as each person contributes their own uniqueness to the groups they choose to join. This is why individual identity plays a crucial role in becoming or joining a group. Everyone possesses multiple identities. Some of these identities are beyond an individual's control and are based on what has naturally been assigned, such as race and culture. Author Paul Hedges describes this phenomenon well: “Whether I think about myself, my family, my team, my gang, my country, or my world, we are always thinking in terms of identities at different levels.”¹⁷ One can be a parent and a worker, a child and a student, of mixed ancestry and human. Many characteristics can be attributed to a person; these collective identities shape the individual and influence their behavior. Brief, “identity theory postulates that self reflects the wider social structure insofar as self is a collection of identities derived from the role positions occupied by the person.”¹⁸

Identity theory and SIT offer insights into how relationships are built and developed.

Researchers at Penn State, Kay Deaux and Daniela Martin seek an integration of identity theory and social identity theory in order to focus on the critical role of interpersonal interactive networks in the construction, validation, and anchoring of social identities. They believe that this proximal relational context as emphasized by identity theory, is much more important than social identity researchers generally have acknowledged, and that a full elaboration of this contexts rest on an integration of identity theory with social identity theory.¹⁹

¹⁷ Paul Hedges, *Understanding Religion: Theories and Methods for Studying Religiously Diverse Societies*, 1st ed. (Oakland, CA: University of California Press, 2021), 140.

¹⁸ Michael A. Hogg, Deborah J. Terry, and Katherine M. White, “A Tale of Two Theories: A Critical Comparison of Identity Theory with Social Identity Theory,” *Social Psychology Quarterly* 58, no. 4 (December 1995): 259. <https://doi.org/10.2307/2787127>.

¹⁹ Michael A. Hogg and Cecilia L. Ridgeway, “Social Identity: Sociological and Social Psychological Perspectives,” *Social Psychology Quarterly* 66, no. 2 (June 2003): 98. <http://www.jstor.org/stable/1519841>.

Steven Hitlin, Ph.D., University of Wisconsin-Madison, finds that “social identity theory and identity theory acknowledge the existence of personal identity.”²⁰ Identity is both comprehensive and individualistic, personal and social. Identities evolve over time, yet certain cultural aspects remain constant. Identity raises the question, “Who am I?” which is subject to change given the context and a person’s role within that context. G.A. Yep explains, “Cultural identities are based on socially constructed categories that teach us a way of being and include expectations for social behavior or ways of acting.”²¹

People behave according to social norms, the rules established by society. Their behavior can differ in specific settings and change as situations evolve. Our affiliations and influences drive shifts in identity. However, “social identity theory is intended to be a social psychological theory of intergroup relations, group processes, and the social self.”²² Yet, there is a connection between social identity and individual representation. Self-identity can derive from family, social connections, biology, environment, race, personal interests, location, society, and so on. Shared representations, such as gender, ethnicity, and race, can influence a person’s interest in a group. Sharing common beliefs based on these identities may heighten a person’s interest in joining a particular group. These “Social identities whether ethnic, national, religious, or occupational shift focus

²⁰ Hogg and Ridgeway, “Social Identity,” 98.

²¹ G.A. Yep, “My Three Cultures: Navigating the Multicultural Identity Landscape,” in *Intercultural Communication: Experiences and Contexts*, eds. Judith N. Martin, Lisa A. Flores, and Thomas K. Nakayama (Boston, MA: McGraw-Hill, 2002), 61.

²² Hogg, Terry, and White. “A Tale of Two Theories,” 259.

away from the characteristics that differentiate us from others, and towards the perception of self as an interchangeable exemplar of some social category.”²³

While Deaux and Martin advocate for the integration of identity theory and social identity theory, other researchers highlight a clear distinction between the two. In *A Tale of Two Theories*, Michael Hogg distinguishes between identity theory and social identity theory, suggesting that “Identity theory is principally a microsociological theory that sets out to explain individuals’ role-related behaviors, while social identity theory is a social psychological theory that sets out to explain group processes and intergroup relations.”²⁴ While explaining that “Both theories place their major theoretical emphasis on multifaceted and dynamic self that mediates the relationship between social structure and individual behavior,”²⁵ Hogg argues that identity theory and SIT “occupy parallel but separate universes, with virtually no cross-referencing,”²⁶ which is problematic for social science.

Still, identity theory and social category theory (SCT) offer insights into SIT, particularly because of the challenges arising from the broad use of the term identity. For Hogg,

One problem with thinking about identity...is that it [the word identity] is used in many ways: self-identity, group identity, the roles we play, and our interactions are all often talked about by this one word ... The language of ‘identity’ is ubiquitous in contemporary social science, cutting across psychoanalysis, psychology, political science, sociology, and history.²⁷

²³ J.C. Turner, *Rediscovering the Social Group: A Self-Categorization Theory* (Oxford, UK: Basil Blackwell, 1987): 50.

²⁴ Hogg, Terry, and White, “A Tale of Two Theories,” 255.

²⁵ Hogg, Terry, and White, “A Tale of Two Theories,” 255.

²⁶ Hogg, Terry, and White, “A Tale of Two Theories,” 255.

²⁷ Hogg, Terry, and White, “A Tale of Two Theories,” 141.

Identity does not account for everything about an individual, so using the term loosely can be misleading. “Identity” is a loose representation of the totality of a person. By definition, identity can encompass a myriad of elements. Understanding the context from which a person identifies is crucial for identification, as suggested by Henri Tajfel.

During his time in a German stalag as a prisoner of war, Tajfel had multiple identities, including a Polish Jew, a French Jew, and a prisoner of war. His identity changed as his situation evolved. Similarly, a person can be an American, Christian, father, mother, worker, or educator; identity depends on the environment, context, or location.

Paul Hedges provides four aspects that are central to identity.

First, identity should be understood within its cultural and social context. For example, identifying as African American describes a heritage, while being of African descent refers to citizenship as an American. Second, identities are rooted in our relationships with others. For instance, women, due to their relational identity with other women, are often perceived as weaker than men, alongside other traits such as perceived behaviors (e.g., submissive and passive). Similarly, men identify with other men based on their perceived gender identity of being aggressive, strong, etc. Third, identity is never singular but plural. We can identify as Christian but also as male or female, Protestant or Catholic, business owners or sociologists. Finally, identity is never stagnant; it is always evolving. We progress from childhood to adulthood, adopting different roles as we navigate through life. Our identities are not fixed and can be regarded as a narrative, a story of ongoing change.²⁸ Identities can change at any time.

²⁸ Hedges, *Understanding Religion*, 142-143.

Equally noteworthy regarding identity is that a social group can consist of two individuals coming together who share a common social relationship identification.²⁹ However, it is conceivable that having a two-person social group can be problematic. If the two are always in agreement, it limits diverse perspectives and opinions. Conversely, having additional members in a group allows for varying views, thoughts, shared experiences, and opinions, resulting in greater sufficiency and insight when making decisions and enabling thorough interpretation of information. Consequently, a larger group allows members to share roles and responsibilities, leading to increased productivity and efficiency.

Social identity theory seeks to explain the thought processes and social conditions that drive intergroup behavior, particularly regarding discrimination, prejudice, and group dynamics behavior.³⁰ SIT brings together personal identity and social influence, which affect group members' thinking and behavior. It is the commonalities with the group that encourage individuals to see themselves as part of the group and not simply as individuals. Identity plays a role in becoming or joining a group because “To varying degrees, people derive part of their identity and sense of self from the organizations or work groups to which they belong.”³¹ As noted previously, individuals embody multiple identities. Some aspects are beyond a person's control, influenced by inherent factors such as race and culture, which cannot change. Defining individuals solely by their social identity overlooks self-representation and the complexities of social identity.

²⁹ Barry Glassner, “Review of *Social Identity and Intergroup Relations* by Henri Tajfel,” *Contemporary Sociology* 14, no. 4 (July 1985): 521. <https://doi.org/10.2307/2069233>.

³⁰ McLeod, “Social Identity Theory.”

³¹ Hogg and Terry, “Social Identity and Self-Categorization,” 121.

Initially, proponents of SIT suggested that in-group identification and preference lead to enhanced self-esteem,³² and today “many theorists also endeavor to link social identity with psychological well-being.”³³ Pirutinsky and Mancuso echo this sentiment, explaining that “Research suggests that social identity is an innate and fundamental psychological process with implications for psychological well-being.”³⁴

Being part of a group imparts a sense of security, support, and acceptance of others. Psychologists confirm that the desire to belong is a fundamental part of human nature. When people feel out of place and their sense of acceptance is threatened, they experience discomfort and self-doubt, which can have long-lasting effects.³⁵ Social identity theory primarily links social identity and psychological well-being to the perceived value of the group to which an individual belongs. A core tenet of SIT “is that individuals prefer to belong to groups that are highly valued: such membership allows them to maintain a positive social identity, which in turn affects self-esteem (Tajfel and Turner 1979).”³⁶ Church membership provides an opportunity to belong to a community of individuals with shared values, interests, and beliefs.

Religious social identity offers structure, providing individuals with something to relate to. There is a sense of community and belonging, with people sharing common interests, fellowship, and goals that enhance their connections self-esteem. “Religion

³² McLeod, “Social Identity Theory.”

³³ Pirutinsky and Mancuso, “Who Are We?” 39.

³⁴ Pirutinsky and Mancuso, “Who Are We?” 42.

³⁵ Mills, “Speaking of Psychology.”

³⁶ Jody Clay-Warner, “Perceiving Procedural Injustice: The Effects of Group Membership and Status,” *Social Psychology Quarterly* 64, no. 3 (September 2001): 226. <https://doi.org/10.2307/3090113>.

gives people something to believe in, provides a sense of structure and typically offers a group of people to connect with over similar beliefs. These facets can have a large positive impact on mental health. Research suggests that religiosity reduces suicide rates, alcoholism and drug use.”³⁷ The benefits of religion and spirituality include a community of trustworthy and safe engagement, rituals that provide regularity and structure, a time for rest, teachings on how to navigate challenging situations, and guidance on exercising compassion, forgiveness, and gratitude.³⁸

However, there can be downsides, including an inflated sense of self and limited interaction with other groups. Experiments have found that groups to which a person belongs (i.e., in-group) tend to rank themselves higher than other groups (i.e., out-groups). This suggests that when participating in a group, individuals experience a sense of conformity as they adjust to the group's dynamics and norms.³⁹ Conformity can be both beneficial and harmful. When a group perceives outsiders as inferior, it allows little room for differing thoughts or opinions, resulting in the misrepresentation of the out-group, bias, discrimination, favoritism, hostility, conflict, and negative outcomes. Embracing diverse thoughts and opinions among ingroup and outgroup members can lead to better decision-making, fostering creativity and engagement.

³⁷ “The Mental Health Benefits of Religion and Spirituality,” *NAMI Blog* (blog), *National Alliance of Mental Illness (NAMI)*, December 21, 2016, <https://www.nami.org/faith-community-leader/the-mental-health-benefits-of-religion-spirituality/>.

³⁸ “The Mental Health Benefits,” *NAMI Blog*.

³⁹ Lily Hulatt, “Social Identity Theory,” *Basic Psychology*, Vaia, last modified October 15, 2022, <https://www.vaia.com/en-us/explanations/psychology/basic-psychology/social-identity-theory/>.

In SIT, the ability of the self to “categorize, classify, or name itself in particular ways in relation to other social categories or classifications”⁴⁰ is referred to as “self-categorization.”⁴¹ Self-categorization, as a contemporary of social identity theory, allows individuals to see themselves not only based on a sense of belonging to a group but also on how they perceive being part of that group. In religion, it provides a framework for individuals to connect with shared beliefs and cultivates a sense of belonging to a community, emphasizing “us” rather than “I.” Theorists and researchers eventually ‘extended social identity theory through the development of self-categorization theory, which specified in detail how social categorization produces prototype-based depersonalization of self and others and, thus, generates social identity phenomena.’⁴² The person now sees themselves interchangeably with other in-group members. Self-categorization explains the key thoughts about how one is perceived in a group and how it aids in developing a sense of self, strongly influencing social identification. Self-categorization theory “recognizes that perceivers are both individuals and group member, explains how and when people will define themselves as individual and group entities and its implications, and examines the impact of this variability in self-perception ('I' to 'we') for understandings of mind and behaviour.”⁴³ It is impossible to avoid self-categorization. Paul Hedges expresses this effectively: “Even if I say I am the kind of

⁴⁰ Jan E. Stets and Peter J. Burke, “Identity Theory and Social Identity Theory,” *Social Psychology Quarterly* 63, no. 3 (September 2000): 224, <https://doi.org/10.2307/2695870>.

⁴¹ Stets and Burke, “Identity Theory,” 224.

⁴² Hogg and Terry, “Social Identity and Self-Categorization,” 123.

⁴³ J. C. Turner and K.J. Reynolds, “Self-Categorization Theory,” in *Handbook of Theories of Social Psychology: Volume 2*, edited by P. A. M. Van Lange, A. W. Kruglanski, and E. T. Higgins, (London, UK: SAGE Publications, 2012), 399-417.

person who does not categorize others, I have immediately put myself into the in-group of ‘people who do not categorize others’ and therefore made an out-group of ‘people who do categorize others!’”⁴⁴

The connections and differences between social categorization theory, self-categorization theory, and social identity theory (SIT) are nuanced. Generally,

Social categorization focuses on its potential downstream negative consequences. Social categorization differs from other forms of categorization in that people tend to place themselves in a category leading them to be partial to members of their own group (ingroup) relative to those from other groups (outgroup) in terms of social preferences, empathic responding, and resource distribution.⁴⁵

In contrast, self-categorization theory assigns the self and others to groups based on attributes like gender, religion, race, and more. Saul McLeod explains that “we categorize people (including ourselves) to understand the social environment.”⁴⁶ By doing so, it enables individuals to understand the social world in which they live. Similarly,

According to SIT, the self concept is comprised of a personal identity encompassing idiosyncratic characteristics (e.g., bodily attributes, abilities, psychological traits, interests) and a social identity encompassing salient group classifications. Social identification, therefore, is the perception of oneness with or belongingness to some human aggregate.⁴⁷

This sense of oneness in social identification provides meaning and can enhance one’s emotional outlook. A social group is simply “a set of individuals who hold a common

⁴⁴ Hedges, *Understanding Religion*, 147.

⁴⁵ Zoe Liberman, Amanda L. Woodward, and Katherine D. Kinzler, “The Origins of Social Categorization,” *Trends in Cognitive Sciences* 21, no. 7 (July 2017): 556-568.

⁴⁶ McLeod, “Social Identity Theory.”

⁴⁷ Blake E. Ashforth and Fred Mael, “Social Identity Theory and the Organization,” *The Academy of Management Review* 14, no. 1 (January 1989): 21. <https://doi.org/10.2307/258189>.

social identification or view themselves as members of the same social category.”⁴⁸

Together,

What the work on social identification and self-categorization provides is a basis for understanding this variousness [in identity] through the concept of social identity and, more precisely, by reference to the dimensions along which the substantive nature of any given identity may vary.⁴⁹

It demonstrates the complexities of human nature, being both unique and sharing commonalities with others.

According to self-categorization theory, social identity, which is simply “a person’s knowledge that he or she belongs to a social category or group,”⁵⁰ and explains how people categorize themselves. Specifically, social identities provide “self-categorization, behavioral guidance (Markus and Wurf 1987), and self-regulation [allowing individuals] to calibrate attitudes, values, and behaviors according to salient identity standards (Oyserman 2009; Reed et al. 2012).”⁵¹ Blake Ashforth and Fred Mael suggest that social classification has two main outcomes: defining others and limiting oneself within the social environment.⁵² These can have positive or negative consequences. If the in-group promotes unity and love for others, then the categorization is positive, as other group members are viewed indiscriminately. However, if the opposite

⁴⁸ Stets and Burke, “Identity Theory and Social Identity Theory,” 225.

⁴⁹ Stephen Reicher, “The Context of Social Identity: Domination, Resistance, and Change,” *Political Psychology* 25, no. 6 (December 2004): 933, <http://www.jstor.org/stable/3792283>.

⁵⁰ Michael A. Hogg and Dominic Abrams, *Social Identifications: A Social of Intergroup Relations and Group Processes* (London, UK: Routledge, 1988).

⁵¹ Nicole Verrochi Coleman and Patti Williams, “Feeling Like My Self: Emotion Profiles and Social Identity,” *Journal of Consumer Research* 40, no. 2 (August 2013): 204.

⁵² Ashforth and Mael, “Social Identity Theory and the Organization,” 20-21.

occurs, groups face discrimination and stereotyping. The way we perceive people can influence how we treat them.

“Self-categorization theory is a recent development that elaborates in detail the operation of the categorization process as the cognitive basis of group behavior,”⁵³ emphasizing the potentially harmful outcomes of self-categorization. Self-categorization can have a powerful impact on social influence within small groups of people “through different processes: status via perceptions of competence, and social identity through perceptions of similarity.”⁵⁴ Evidence of the dangers of self-categorization extends back to Henri Tajfel’s early research. His minimal group experiments, “originally intended as a baseline from which one could determine the necessary and sufficient conditions for collective prejudice, showed that mere categorization can produce inter-group differentiation.”⁵⁵ According to Tajfel, ingroup bias occurs when people define themselves in relation to another group, making their group the preferred one and differentiating themselves from the less favored group (Billig & Tajfel 1973).⁵⁶ Embedded within the social identity theory that Tajfel and Turner developed is the idea that people, “in order to achieve a positive self-definition, seek to advantage our ingroup over comparison outgroups,”⁵⁷ which may involve damaging characterizations or actions towards the out-group(s).

⁵³ Hogg, Terry, and White, “A Tale of Two Theories,” 260.

⁵⁴ Hogg and Ridgeway, “Social Identity,” 98.

⁵⁵ Steven Reicher, “Tajfel, Henri,” *People, The Legacy of European Social Psychology*. <https://history.easp.eu/people/tajfel-henri>.

⁵⁶ Zafar, “Review of *Henri Tajfel*,” 339.

⁵⁷ Reicher, “Tajfel, Henri.”

Religious groups illustrate the biases, stereotypes, and opposing views that can arise between in-groups and out-groups. For example, Hedges describes how Christians may formulate their identity in a way that opposes other religious groups: “If Christians form one in-group with Buddhists as their out-group, the Christians might stress their belief in God as an important difference.”⁵⁸ This is also true within similar and identical denominations. When groups align with one faction over another, division can arise, and various factors can contribute to the animosity among congregations, including socio-economic classifications, race, favoritism, and cliques, which may lead to infighting and further division.

Still, despite these potential dangers of social identities, the research remains clear: “Psychological theorists and practitioners have empirically demonstrated that social connection is a critically important human need.”⁵⁹ The current mental health crisis underscores the consequences of lacking social identities. In their article, “Religious Social Identity as an Explanatory Factor for Associations between More Frequent Formal Religious Participation and Psychological Well-Being,” Emily Greenfield and Nadine Marks argue compellingly that “Social identity theory, therefore, provides a firm theoretical ground for exploring religious social identity as an explanatory mechanism for associations between more frequent formal religious participation and psychological

⁵⁸ Hedges, *Understanding Religion*, 149.

⁵⁹ Emma Seppala, Timothy Rossomando, and James R. Doty, “Social Connection and Compassion: Important Predictors of Health and Well-Being,” *Social Research* 80, no. 2 (Summer 2013): 412-413. <http://www.jstor.org/stable/24385608>.

well-being.”⁶⁰ They explain that, according to SIT, “more frequent formal religious participation would be associated with having a closer identification as a member of one’s own religious group, and that this aspect of identity, in turn, would account for higher levels of psychological well-being.”⁶¹

Studies show that individuals who attend church services at least once a week have a 26% lower mortality risk. Church attendance and religious participation are not determined by health; for those who do adhere to such practices, it provides meaningful social integration and is believed to contribute to longevity, better well-being, and improved mental health.⁶²

Conclusion

Mother Theresa once said, “Being unwanted, unloved, uncared for, forgotten by everybody—I think that is a much greater hunger, a much greater poverty than the person who has nothing to eat.”⁶³ Social identity theory, identity theory, self-categorization, and social categorization address the human need for connection. Such connection supports deep emotional needs that are often unmet among those suffering from poor mental health.

⁶⁰ Emily A. Greenfield and Nadine F Marks, “Religious Social Identity as an Explanatory Factor for Associations Between More Frequent Formal Religious Participation and Psychological Well-Being,” *The International Journal for the Psychology of Religion* 17, no. 3 (December 2007): 245.

⁶¹ Greenfield and Marks, “Religious Social Identity,” 245.

⁶² Ying Chen, Eric S. Kim, and Tyler J. VanderWeele, “Religious-Service Attendance and Subsequent Health and Well-Being Throughout Adulthood: Evidence from Three Prospective Cohorts,” *International Journal of Epidemiology* 49, no. 6 (December 2020): 2030-2040.

⁶³ Gwen Costello, *Spiritual Gems from Mother Teresa* (Waterford, CT: Twenty-Third Publications, 2008), 14.

Identity is complex; it is not stagnant but fluid, constantly shifting and changing based on context. It influences who one is at any given time and who one becomes. Various theories from psychology provide insight into how individuals develop their identities and the implications of those identities. Social identity theory (SIT) describes the relational dimension of identity and seeks to explain group processes and intergroup relations. Identity theory aims to explain individuals' role-related behaviors while considering how relationships play a role in society.⁶⁴ Self-categorization theory addresses how individuals perceive themselves and categorize others. These overlapping theories provide insight into the self and how one functions within a group setting, resulting in both positive and negative outcomes. These are just a few fields of study that illuminate individual and group behavior, perception, and the reasons why some seek to join a particular group while others do not, along with the impact that the group has on individuals.

Being part of a group builds esteem, confidence, and pride. A sense of purpose and self-worth can promote optimism and hope, creating a solid identity. However, it must be understood that each individual brings their perceptions of who they are and how their identity is influenced by ethnicity, society, social norms, gender, language, family, friends, and life experiences. Understanding the role of Social Identity Theory (SIT) and how it influences an individual's mental health is not simplistic; consideration must be given to the complexities of the roles identity plays in humanity, how personal identity, self-categorization, and social categorization influence behavior, and how negative

⁶⁴ Hogg, Terry, and White, "A Tale of Two Theories," 266.

consequences can result if an in-group (the group in which one belongs) excludes others, resulting in prejudice and discrimination.

As loneliness, anxiety, and stress increase, extensive recent research has explored the positive correlations between religion and health.⁶⁵ Studies have been conducted to test religion and psychological well-being, and while findings are small, “Indices of religiousness and spirituality are robustly associated with positive outcomes concerning happiness and well-being.”⁶⁶ SIT provides an explanation of this correlation by detailing the benefits individuals experience from belonging to a social group and forming a social identity.

Such findings and the lens of SIT are hopeful, providing churches with an opportunity to enhance the emotional well-being of individuals who view religion as a means to address stressful situations. Creating an environment for those experiencing distress would benefit not only the individuals but also society as a whole. However, it is essential to recognize that some conditions require care that only licensed healthcare professionals can provide. The aforementioned theories are not intended for diagnosis but serve as a guide for those with the necessary skills to assist in the well-being of others.

Social identity theory suggests that those seeking relief from loneliness and isolation can find well-being through building relationships, having a sense of belonging, and gaining self-esteem provided by a religious identity. As the Church incorporates educational programs that inform congregants about mental health, it can become a

⁶⁵ Greenfield and Marks, “Religious Social Identity,” 245-259.

⁶⁶ Brenda R. Jackson and C. S. Bergeman, “How Does Religiosity Enhance Well-Being? The Role of Perceived Control,” *Psychology of Religion and Spirituality* 3, no. 2 (May 2011): 149-161.

conduit for removing stigma and creating a safe, open environment for individuals to develop a religious identity and heal.

CHAPTER SIX

PROJECT ANALYSIS

Introduction

The number of individuals suffering from mental illness has been increasing, and unfortunately, the stigma surrounding mental health prevents some people from getting the assistance they need. A lack of understanding and a refusal to engage in discussions have contributed to the ongoing stigmatization. As the World Health Organization (WHO) explains, community providers can assist in dispelling myths, encouraging those in need to seek support. Knowledge and awareness within a supportive community can help those suffering to feel safer and more comfortable reaching out for assistance.¹

One of the major factors contributing to the increase in mental health concerns is social isolation. The *International Journal of Psychology* reports that “loneliness is a predictor of depression and anxiety and recently Santini et al. (2020) demonstrated that social isolation increased feelings of perceived isolation, which in turn predicted higher

¹ World Health Organization, “How to Talk about Mental Health,” *mhGAP Community Toolkit: Mental Health Gap Action Programme (mhGAP)*, World Health Organization, 2019, <http://www.jstor.org/stable/resrep27898.11>.

depression and anxiety symptoms.”² During the pandemic, places where people usually sought comfort and relief were unavailable, forcing those experiencing these symptoms to find alternative ways to cope.

The church serves as a sanctuary for many. Being part of a church community offers an opportunity to share beliefs and build connections, which can help reduce feelings of loneliness and isolation not only for the Black church but for all whose mission is to honor the Great Commandment. Biblical teachings and sermons provide guidance, comfort, and a sense of identity during tough times. During the pandemic, anxieties were high. Daily life was disrupted as people searched for information on how to adapt to a new way of living, including details on health, obtaining vaccines, and managing social interactions in a limited environment.

Jubilee Community Church (JCC), located in Miamisburg, Ohio, serves members from various counties and areas, with the predominant membership being of African American (Black) descent. The location of its members includes Butler, Franklin, Hamilton, Montgomery, and Warren counties, as well as online members from Texas, Georgia, and Kentucky. Its membership is diverse, encompassing men, women, and children. Members include physicians, attorneys, firefighters, police officers, educators, engineers, government workers, accountants, bookkeepers, social workers, business owners, retirees, and more. Founded by Palmer Jason in 1996, JCC addresses the needs of individuals who may possess material wealth but feel a sense of emptiness, lacking fulfillment and meaning. When people feel empty inside, there is a lack of joy—a

² Marcin Owczarek et al, “How is Loneliness Related to Anxiety and Depression: A Population-Based Network Analysis in the Early Lockdown Period,” *International Journal of Psychology* 57, no. 5 (October 2022): 585-596. doi:10.1002/ijop.12851.

symptom of many mental health conditions.³ Studies have demonstrated that “materialism is associated with lower levels of well-being, less pro-social interpersonal behavior, more ecologically destructive behavior, and worse academic outcomes. It also is associated with more spending problems and debt.”⁴

During the pandemic of 2019, JCC needed to find a way to connect with congregants as they faced fear, isolation, and anxiety caused by the encouraged separation. As the pandemic began to ease, fear persisted; JCC aimed to ease some of these worries by adding a second worship service. This allowed congregants to gather while feeling safe and maintaining distance from one another. However, this only addressed the physical aspects of mental health. Simply being in the church building was not enough to foster mental well-being, and congregants still couldn't fully connect due to the safety measures in place.

Beyond simply gathering to worship together, people needed a safe environment where they could express their concerns affecting emotional well-being—a place where trustworthy individuals safeguard shared information. Congregants often reached out to me, the Assistant Pastor, when they felt overwhelmed, which provided some comfort. However, if more church leaders were trained, additional individuals could find support while navigating grief, loss of income, illness, divorce, or other life events that cause anxiety, emotional distress, and other mental health challenges. Accompaniment—

³ “Anhedonia,” Symptoms, Health Library, Cleveland Clinic, last modified July 26, 2023, <https://my.clevelandclinic.org/health/symptoms/25155-anhedonia>.

⁴ Tim Kasser, “What Psychology Says About Materialism and the Holidays,” interview with APA, American Psychological Association, Press Release, December 16, 2014. <https://www.apa.org/news/press/releases/2014/12/materialism-holidays>.

walking alongside a person who is suffering—offers a significant, impactful support. Sometimes it is simply listening to a person’s concerns.

The Bible addresses Christian responsibility: “‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself’” (Matt 22:37-39). The story of the Samaritan found in Luke 10 illustrates how an ordinary person can provide relief when witnessing someone in distress by simply meeting their basic needs. Additionally, The Salvation Army, an evangelical part of the universal Christian Church, demonstrates how being present, listening, and observing allow Christians to recognize needs and inspire supportive action.

Growing public awareness of mental health can reduce reluctance to discuss it and normalize conditions that everyone will likely experience at some point in their lives. Recognizing that mental health encompasses emotional, psychological, and social well-being is crucial for understanding its impact on overall health. The Church has a significant opportunity to act as a guide. Research shows that ministry leaders are well-positioned to help destigmatize mental health by creating programs and training and by connecting people with supportive environments that can alleviate symptoms. “Faith and community leaders are often the first point of contact when individuals and families face mental health problems or traumatic events. In fact, in times of crisis, many will turn to trusted leaders in their communities before they turn to mental health professionals.”⁵

⁵ “Mental Health,” Substance Abuse and Mental Health Services Administration (SAMHSA), last modified November 8, 2024. <https://www.samhsa.gov/mental-health/>

This research aims to educate, identify, develop, and edify JCC leaders about their understanding of mental health, how mental health is defined, and whether the church is a suitable place for discussions about it. “If ministry leaders are trained to recognize the signs of distress (anxiety and depression), then they will be equipped to exercise compassion and guide congregants to the help they need.” This will determine if JCC leaders are willing to serve as a pilot site for training specific to mental health, incorporating a program that includes recognizing its signs and assessing congregants' acceptance of such a program through feedback and their willingness to incorporate a mental health program as part of its teachings and preachings.

This project aimed to explain how the Bible addresses mental health, how an organization can achieve its objectives while considering mental health, how church leaders, if trained to recognize the signs of mental health, can support mental health programs by coming alongside those suffering and guiding them to the help needed, and how being part of a group and deriving a sense of identity within a church community can be vital in changing perceptions about mental health.

Methodology

Several data collection methods were employed to conduct this study, including questionnaires, face-to-face meetings, Zoom calls, open discussions, one-on-one interviews, and journaling prompts. A camera was set up to capture participants during sessions and group discussions. The goal was to observe and note the nonverbal cues (such as ticks) that participants exhibit while sharing information and also record their questions and discussions related to project modules (See Appendix A for timeline).

Questionnaires facilitated the collection of unbiased data and assessed participants' knowledge regarding mental health. Comprised of open-ended questions, the questionnaires allowed participants to express their thoughts, feelings, and perspectives without interference from others or fear of judgment. These questionnaires were administered both before and after the project to determine if participants' opinions or thoughts changed after receiving researched information and to assess whether the project fostered a deeper understanding of mental health. This process also allowed participants to provide feedback on the complexity of the subject matter (See Appendix B for Questionnaire).

The questionnaires included open-ended questions about clinical depression, anxiety, and distress. To facilitate data collection, the pre-study questionnaires were administered to participants in person, as submitting or requesting information via text or online links could have caused delays or hindered adequate sampling. Additionally, before the pre-questionnaire and study lessons, participants received statistical information derived from census data about mental health to ensure they had a preliminary understanding of the topic and to promote a more productive meeting. This information focused on distress-related topics, including poverty level, the economy, insurance, education, race, and other factors from a specific period (2024) that may have affected an individual's mental health.

Research findings related to mental health were presented over a six-week period. The goal of these sessions was to enhance participants' knowledge of mental health and provide deeper insight into mental health as it relates to distress, within the context of JCC. Furthermore, sharing the research highlighted the time, effort, and validity of the

project, fostering collaboration within this framework. Familiar, accessible language was employed to present research findings, ensuring that all participants could comprehend the information. This approach prevented participants from feeling incapable of providing essential feedback. Slides on Zoom engaged participants with the subject matter, offering visual learning opportunities. The slides included bullet points for each foundational paper and provided an easier way to take notes, which could be utilized for further discussion or journal writing. Visualizations were structured based on research findings, facilitating timely delivery and focus. Presenting the research this way fostered the evaluation of the knowledge gained by participants and identified areas needing further investigation. Improvement in the participants' understanding of the subject matter would encourage investment in developing programs that support mental health.

Once the research findings were shared, open discussions commenced. These discussions started with an open-ended question following each research topic presentation. Group discussion questions after the presentations were also open-ended and focused on clinical depression, anxiety, and distress. The open discussions enabled participants to hear various viewpoints and diverse opinions. These perspectives opened the door to further considerations, additional insights, and enriched dialogue. Capturing their feedback through notetaking, asking questions, and reviewing previously recorded Zoom calls facilitated feedback collection and provided an opportunity to understand what is known within the context, what remains unclear, and whether further research is required or if additional clarity in conveying the information is needed. Throughout the open discussions, participants' engagement with the subject matter was documented. Notes were taken when participants showed signs of interest (i.e., nodding, eye contact,

sitting upright, actively participating in the discussion etc.) and disinterest (i.e., slouching in their chairs, lack of eye contact, specific facial expressions, frequently looking away, distractibility, lack of engagement, etc.). Additional signs of disinterest could include opting out of the discussion, appearing closed off, checking their phones or other devices, or becoming restless. One important consideration during group discussions, especially regarding mental health topics, was that the information could be triggering. Any or all of these cues serve as indicators for me, the researcher, to determine whether the subject is suitable for the identified context.

Participants were also interviewed individually via Zoom to ensure their comfort with the subject and to encourage deeper communication (See Appendix D). These interviews addressed questions not covered during the open discussions and explored the participants' additional thoughts on the presented topics. Since the ministry leaders varied in age and occupation, conducting individual interviews enhanced understanding of different generational and ethnic perspectives. These insights will inform future research as gaps in the subject are revealed. Similar to the group meetings, these individual sessions allowed for visual observation of signs of disinterest and other potential obstacles to discussing the topic. Questions were presented to provoke additional thoughts or inquiries, share any points needing clarification, and discuss relevant subjects related to mental health. Everyone was eager to engage, as the goal was to encourage conversations that might not arise otherwise in a group context. These one-on-one meetings allowed assessment of whether the participants could benefit from additional data or whether the research findings required clarification.

The final method for gathering data featured journal reflection prompts. These questions differed from the group discussion questions and the individual meetings (See Appendix C). The journals offered participants an opportunity to share their reactions without fear or apprehension about others' thoughts and opinions. Furthermore, journaling was not time-restricted, facilitating greater introspection. It could be completed in just a few minutes with a few sentences or could extend to numerous pages as thoughts emerged from week to week. Conducting research in this manner provided unfiltered, unbiased feedback.

Implementation

Individuals involved in the research study were ministry leaders of Jubilee Community Church (JCC) from diverse backgrounds and ethnicities. They were identified as leaders within the church, serving in or heading various initiatives and programs. Before participating in the project, these potential participants received an informed consent letter. This letter included a description of the research, the procedures involved, and eligibility conditions (i.e., ages 18 to 65 and above), as well as the benefits of participation, their roles as volunteers for the study, and a confidentiality statement. Informed consent letters were delivered to each person through hand delivery, email, or text messages, along with a request for them to return them.

Once the signed informed consent forms were returned, nine participants were identified. They represented various genders, ethnicities, and educational backgrounds: seven females, two males, and two ethnicities, with education levels ranging from high school graduates to advanced degrees. The group included two medical physicians, a

business owner, a retired government worker, a librarian, an administrator, a homemaker, and two engineers, all current members of JCC and ministry leaders. These demographics reflected the average profile of JCC. After selection, participants received statistical data from census reports of local counties, which served as a framework for the project.

A questionnaire was administered at the beginning of the first study meeting, and an identical questionnaire was given at the end of the study. The questions were generated with the help of healthcare professional Whitney Sims, LLPC, a Family Preservation Manager who worked closely with me to evaluate each question to determine whether it would address my hypothesis. Her participation was essential in ensuring that the questions addressed the hypothesis of proving or disproving it and in helping to prevent any emotional triggering that the questions might cause. The pre- and post-study questionnaires were identical in order to evaluate whether participants' perspectives on mental health (e.g., anxiety and depression) shifted as a result of the study. The questionnaire assessed whether, after receiving information on mental health, participants' thoughts about mental health remained unchanged or if the acquired knowledge helped reduce the stigma surrounding it. Such data could illustrate the value of providing mental health training for the church and determine whether such training would be acceptable to ministry leaders.

The research was conducted over six weeks. The first session was live and served as an introduction, while subsequent sessions two through five were held via Zoom. The final meeting was also live, taking place at JCC. Each meeting lasted approximately two hours, with ten-minute breaks.

Whitney Sims, LLPC, a Family Preservation Manager who is not a member of JCC but was recommended by a member of JCC, attended each meeting to ensure that the information shared did not delve into the medical aspects of mental health. In speaking with Whitney prior to asking for her participation, she shared her work with children in the mental health field and her passion for mental health. After spending over an hour in a one-on-one discussion with her, listening to her background and passion for mental health and sharing my project, she willingly agreed to participate. No fee was requested by Whitney. However after our conversation, I personally provided her with compensation for her time. With a Bachelor of Arts in Psychology and a Master of Arts in Clinical Mental Health Counseling, Whitney proved to be an invaluable asset in keeping us focused on non-medical expertise. Receiving support from a skilled professional was essential in grasping the complexity and sensitivity of the subject matter.

The next portion of this paper summarizes the weekly sessions and their content. This process does not imply it is the only method for gathering relevant data but can serve as a framework for implementing mental health programs within the church.

Title: Reducing the Stigma of Mental Health in the Church

Week 1 (January 27, 2025): Introduction

Participants were welcomed and thanked for their willingness to be part of the project. Informed consent forms were collected, and the pre-questionnaire was distributed and collected. An overview was provided of what to expect in the coming weeks,

including the methodology used to collect data. Participants were also informed of their rights and responsibilities regarding the project, as well as the rights of the principal investigator. As the principal investigator, questions related to the project were addressed. Additionally, during the first meeting, journals were distributed to capture participants' thoughts from each project module, along with a question for consideration based on that week's specific project module. The journals were designed to be unidentifiable to maintain anonymity and encourage free expression. Participants were also informed that individual interviews would be conducted via Zoom over the six-week period. This arrangement provided participants with flexibility in sharing feedback (i.e., not having to travel to the site) and enabled the principal investigator to conduct the interviews and gather unspoken data (e.g., visual clues) to evaluate the effectiveness of the hypothesis.

Week 2 (February 3, 2025)

A biblical lesson on mental health (i.e., clinical depression) was presented. The biblical lesson came from Luke chapter 10, verses 25 to 37, particularly verse 27. “‘Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind’ ‘Love your neighbor as yourself.’” The story of the Samaritan and the parable Jesus shared illustrated that God’s commandment extends to everyone. Loving others means helping and caring for all those in need, regardless of their background or social status. The lesson highlighted key figures, including, but not limited to, the Samaritan, the Priest, the Levite, the injured man who is clearly in distress, and the innkeeper. Themes of this parable included God’s righteousness, love, compassion, the definition of a neighbor, prejudice, and altruism. Open discussions commenced after the

lesson, along with a journal question based on the lesson presented to reflect upon prior to the next meeting.

Week 3 (February 10, 2025)

A historical lesson on mental health (i.e., clinical depression) was presented, focusing on the Salvation Army and its founders, William and Catherine Booth, as well as their efforts to bring salvation to the poor, vulnerable, and destitute. This lesson addressed how their organization began and how they were able to achieve their objective by acknowledging the distress experienced by those living on the streets of London, and the approach they took to fulfill their initial goal of bringing salvation to the poor by first living out the principle of “loving their neighbor.” In doing so, they not only achieved their mission but also unknowingly provided relief for those struggling with mental health issues, specifically distress. Open discussions ensued after the lesson, and a journal question based on the lesson presented was given for reflection prior to the next meeting.

Week 4 (February 17, 2025)

A theological lesson on mental health (i.e., clinical depression) focused on the Church and its role and responsibilities regarding the care of congregants. This lesson emphasized the Church as an institution—a society of organized believers grounded in a religious belief in Christ and living out Christ’s teachings: scripture affirms, “For it is by grace you have been saved, through faith—and this is not from yourselves, it is the gift of God—not by works, so that no one can boast. For we are God’s handiwork, created in Christ Jesus to do good works, which God prepared in advance for us to do (Eph. 2:8-

10).” Understanding how the Church has evolved over the years and what Christ expects of its followers is essential to fulfilling His commands. This involves embodying Christ to others, being the church where people can find a sense of belonging, and where Christ’s love is demonstrated. After the lesson, open discussions commenced, and journal questions were given specific to the lesson for reflection prior to the next meeting.

Week 5 (February 24, 2025)

An interdisciplinary lesson on mental health (i.e., clinical depression) focused on Social Identity Theory (SIT). Founded by Henri Tajfel and his student, John Turner, SIT posits that individuals derive part of their identity from their membership in social groups. The Church functions as a social group that impacts society. With anxiety and distress on the rise, the Church can have a significant influence on behavior. SIT offers insights into the importance of maintaining healthy external relationships, which may help reduce symptoms related to mental health, including, but not limited to, loneliness, sadness, and withdrawal. SIT may also provide fundamental principles that the Church can adopt to clarify its role in the mental health crisis. Being part of an in-group, a group with a shared ideology, can provide a sense of meaning and promote mental well-being. Discussions commenced after the lesson, followed by a journal question specific to SIT to reflect on prior to the next meeting.

Additionally, between the second and sixth group meetings, the nine participants were interviewed individually via Zoom. The interviews occurred between February 24 and March 4, 2025. The questions were conversational in nature and typically lasted between ten and twenty minutes. During each interview, participants were asked about

their experiences related to depression and anxiety. These questions were based on what they perceived as the most challenging aspects of addressing mental health and whether they had ever interacted with someone facing mental health issues. If the conversations led to a positive response, they were asked how they had dealt with it or whether they had addressed it at all. Furthermore, they were asked about the signs they noticed that indicated the person they interacted with was experiencing these issues and how comfortable they felt engaging with them, including any fears or apprehensions they might have had. They were also asked for unsolicited thoughts on whether they believed the church could play a role in dispelling the stigma surrounding mental health.

Week 6 (March 3, 2025)

A Post-Project Questionnaire with the same questions as the pre-questionnaire was distributed to determine whether the responses had changed. Participants were thanked, and inquiries were made regarding the next steps of the project.

Summary of Learning

After reviewing the participants' candid discussions and written feedback, a wealth of insights emerged regarding their definitions of clinical depression and their feelings about mental health. The following are the initial thoughts by participants prior to attending the lessons.

In the pre-questionnaire, when asked, “Can you explain what you understand clinical depression to be and some of the key symptoms a person might exhibit?” there were some consistent responses, along with a few that were mentioned only once. These

responses are unfiltered, providing an accurate representation of the participants' thoughts and beliefs. The most frequent response was “detachment from others, hermit, may not dress or bathe.” The second most common response was, “fatigue, lethargic, confides in no one, closed off, nonverbal, feelings of sadness, no desire to do anything, hopelessness.” Responses listed only once include “depressed mood,” “apathy,” “lack of interest in normal activities over a six-month period,” “insomnia,” “oversleeping,” “appetite up and down,” “sense of loneliness,” “misunderstood,” “trouble communicating ideas or feelings,” “a disorder diagnosed by a physician,” “extreme highs and lows,” “self-harm,” “acute or chronic/situational or random,” and “depression improved with medication.”

These responses suggested that some project participants are aware of the behaviors that signal someone is experiencing distress; however, this awareness does not imply a willingness to intervene or a responsibility to approach such individuals, as exemplified by the Samaritan principle. Some signs may not be visible in public settings (i.e., church). These responses emphasize the importance of having a relationship with the person experiencing distress, which may not be feasible in large settings. For instance, “lack of interest in normal activities over a six-month period,” “oversleeping,” “appetite up and down,” “a disorder diagnosed by a physician,” and “self-harm” each signify the necessity of knowing or observing a person's normal behavior through a developed relationship. Although participants acknowledged how distress might be observed, it does not suggest that they feel able or comfortable approaching these individuals, especially if they are not known. The Church encourages visitors and strangers, which presents a unique opportunity to provide support for those who may be

experiencing distress by educating leaders about how to approach those who are unknown. When people fail to identify individuals suffering from poor mental health, those individuals continue to suffer.

Responses to question number two, “What are the signs someone has experienced or is currently experiencing clinical depression?” The highest responses were, “no longer gathering with others,” followed by the second highest responses, “quiet” and “mood swings (angry/sad).” The next highest responses included “poor hygiene,” “changes in appetite,” “fatigue (tiredness, exhaustion),” and finally, the singular responses were “tearful,” “disheveled,” “drinking more than usual,” “always happy then go away for a while,” “lethargy,” “negative attitude,” “self-deprecating,” “change in sleep pattern,” “worry and fear of future,” “despair (hopelessness),” “distant,” “dark thoughts,” and “lack of joy.” Similarities to question one included “no longer gathering with others,” “seclusion,” and “detachment from others,” all of which received the highest marks, suggesting they are the number one sign, though not the only sign of someone experiencing distress. This again emphasizes the importance of relationships. However, if the church is to become a resource for those experiencing distress, particularly someone who is unknown (i.e. visitors, strangers), being trained to recognize observable signs in them is crucial.

Responses to question number three: “How does clinical depression affect an individual mentally, emotionally, physically, and spiritually?” The symptoms identified were: “mind becomes numb,” “shutting out love,” “not getting dressed or eating,” “weight up and down,” “may be uninvited to events because of attitude,” “unstable, absent from God.” Other responses included: “cannot pay attention,” “unrealistic

thoughts,” “feeling inadequate (sadness, hopelessness),” “self-neglect,” “not spending time with God,” “self-medicating (drugs, food, alcohol).”

Again, I reiterate that churches, as gathering places for those with a common faith and purpose, welcome everyone. People who attend church may not always be known to regular attendees, but that does not diminish their importance, especially regarding their mental health. For some, it may be the very reason for attending, as research suggests that persons experiencing distress reach out to church members.⁶ Responses to these questions indicate the ability to understand them, which may be unlikely. Approaching unfamiliar individuals can cause anxiety, and learning how to do so through appropriate training can alleviate some of the associated stress.

There were various responses to question four, “What distinguishes clinical depression from other types of mental health disorders? Have you ever experienced clinical depression? If yes, in what ways did you experience it, and for how long did you experience clinical depression?” One response was given four times, another was offered twice, and all other responses were provided only once. The response with the most acknowledgments was, “no focus, sadness, and self-esteem.” The response mentioned twice was, “I don’t believe there are clear-cut distinguishers.” The list of singular responses included: “always low versus occasional ups and downs,” “never clinically depressed,” “financial stress caused depression (suicidal),” “not sure,” “yes, started with COVID-19 and continues,” “believe induced by Satan,” “chronic depression over 30

⁶ Linda M. Chatters, Ann W. Nguyen, Robert Joseph Taylor, and Meredith O. Hope, “Church and Family Support Networks and Depressive Symptoms Among African Americans: Findings from The National Survey of American Life,” *Journal of Community Psychology* 46, no. 4 (May 2008), doi.org/10.1002.jcop.21947.

years,” “has to be diagnosed by a physician,” “family members have had it for several years,” “refused to take medication,” “narcissism,” “high ups and downs,” “over-exaggerate,” “lying,” “criminal acts,” “talking about yourself all the time.”

Responses to question four were self-revealing. While one response received the highest reply, participants felt comfortable sharing their personal experiences with distress. My awareness of their distress was limited, and although the letter granting me permission to conduct this project clearly outlined its purpose and what was involved, they still wished to participate. In fact, one participant, who thought I might ask her to leave the project, requested to meet with me individually. During that discussion, she sought reassurance that I would not remove her from the project, believing it could have a positive impact on the church. She went on to explain her reasons and promised that if she felt uncomfortable at any time, she would withdraw from the project. She remained throughout the entire project and continues to inquire about how it is progressing.

Survey question five, “What does the Bible say about clinical depression?” elicited the most responses. Only two replies were consistent: “Trust God” and “don’t know.” Other feedback in response to this question included: “be joyful,” “praise God in all situations,” “bring sadness to God,” “a spirit that attacks and exalts itself against God,” “not to worry,” “lean not to our own understanding,” “God is with us,” “a lot of verses in the Bible,” “pray about everything,” “worry about nothing,” “it does not exist,” “we will have trouble encourage and support each other,” “we have hope in Jesus,” “story of Paul endured evil spirits of anxiety and depression,” “cast all cares on God,” “God will never leave you or forsake you,” “do not be afraid,” “He loves you,” “God will take care of you,” “rest and regroup,” “the Holy Spirit gives you power.” These types of responses

indicate that some participants believed that inundating people with scripture would alleviate their concerns.

As a pastor in this context, these responses were not surprising. Often, when teaching and preaching, leaders use scripture as a salve to promote healing. However, scripture alone is not a cure, and while those who suffer from distress may find momentary comfort in it, there are remedies that accompany these texts and also support healing. William Booth, the founder of the Salvation Army, saw this firsthand. In his objective to preach salvation, which is what Christ wants for everyone, he realized that other things needed to accompany scripture and his preachings. What the Salvation Army did was come alongside the suffering, providing resources that alleviated their distress. They took the command to “love thy neighbor as thyself” literally, providing action with scripture.

In response to the final question, “How can ministry be improved for those persons who have experienced or are currently experiencing clinical depression?” the most common response was “support from the church, cell groups, clergy with a mental health focus.” The second most common responses, with at least two participants offering the same feedback, included “offer prayer and communion,” “talk about what is bothering them,” “be genuine,” “acknowledging it,” “come alongside, listen to them, teach the true meaning of faith.” Lastly, with only one response, “offer to be there (for a time), pick them up for church,” “take a meal,” “show love, patience, kindness, peace, self-control,” “having a confidant (a spiritual one),” “a loving and safe space,” “recognizing prayer and God alone won’t fix clinical depression,” “identify it,” “realize it

is spiritual,” “focus on God,” “show compassion without judgment or shaming,” and “support groups.”

The highest response to question six may help dispel the stigma associated with mental health and promote honest communication. Implementing programs that specifically address mental health (i.e., distress) offers an opportunity to support those experiencing it. Not everyone has access to healthcare, and the number of healthcare workers addressing mental health is currently facing a shortage.

According to data from the Kaiser Family Foundation, 47% of the U.S. population in 2022 was living in a mental health workforce shortage area, with some states requiring up to 700 more practitioners to remove this designation. The reasons underlying this shortage are complex, causing many mental health professionals to feel there may be more challenges than solutions to this growing problem.⁷

Analysis of Individual Interviews

When asked, “What do you believe are the most challenging aspects of dealing with depression?” Here is a summary of those conversations: some participants explained that not knowing what to look for can make identifying the signs of mental distress difficult. Others described how being willing to listen and knowing how and where to guide the person suffering requires time and energy.

In response to the second interview question, “Have you or do you know of anyone who has experienced clinical depression, and if so, what were your feelings about it?” Participants identified individuals in their lives, including themselves, who exhibited symptoms of mental health issues, such as depression and anxiety. These individuals

⁷ Lindsey Phillips, “A Closer Look at the Mental Health Provider Shortage,” American Counseling Association, May 2023, <https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/a-closer-look-at-the-mental-health-provider-shortage>.

included family members, siblings, and friends. At times, the participants expressed judgment because some individuals were not adhering to their medication regimens. While they felt sadness for those suffering, they also experienced frustration at their inability to resolve the issue. One interviewee said,

As a medical professional, I have worked with many individuals struggling with clinical depression. Therapy and medication have proven beneficial. However, chronic conditions can drain healthcare providers due to the challenges of resolving these issues. Some individuals resorted to self-medicating with alcohol and drugs, leading to sadness for those affected. Some who sought help through oral medications and therapy did not experience success.

This response illustrates the time and energy necessary to assist those struggling with clinical depression. It also highlights the shortage of healthcare workers available to provide this support. This participant, as a healthcare professional, acknowledges that healthcare providers could use additional support, and if the church can offer that help by showing compassion and emotional support, it could potentially help reduce the number of individuals experiencing distress.

Various responses were offered to the third interview question, “What signs did they exhibit? Are you comfortable interacting with persons who exhibit signs or clinical depression? Explain your position.” The following is a summary of those responses: One participant shared, “Some of the signs exhibited included excessive crying, a lack of self-care, a cessation of activities they previously enjoyed, withdrawal, changes in demeanor or countenance, and a refusal to respond to phone calls, emails, or texts.” “In conversations, the person would express thoughts such as, “I’m done with this,” or “I don’t want to live anymore.” “Because I love them, I feel comfortable interacting with them. Some become quiet and avoid making eye contact; their speech slows, making it difficult to engage or pay attention to their surroundings.”

Each of these responses indicates a relationship with the individuals they interacted with, and due to that relationship, they felt comfortable engaging with and offering support to them, which aligns with Social Identity Theory. One participant mentioned a practice they have with a friend who is suffering by having weekly phone calls to check in and reassure her that she is loved, seen, and heard. This reinforces my point that relationships are important; when there is a personal connection, individuals feel more at ease approaching and interacting with someone in distress. However, none of the participants mentioned their interactions with individuals they did not know.

In response to the final interview question, “Do you think there is a stigma associated with mental health, specifically in issues like depression, and what are your thoughts relative to the church's role in helping to remove it?” participants agreed that a stigma still exists. There was significant discussion about the role of the church. One response was, “It is not overtly addressed because the church wants to be viewed favorably. Phrases like ‘give it to God’ are directed at the sufferer.” Other responses included, “The church can help by being non-judgmental; it’s not always ‘they need to go to God first’ because many times they have.” “Openly talking about mental health is crucial.” “The church has a lot of influence on the people they minister to. If the church speaks about mental health, depression, as it does on other issues like tithing, sinning, and drugs, the topic will become more comfortable for everyone.” All participants unanimously agreed that the church can be influential in addressing mental health by being a guide, exercising empathy and understanding through its teachings and preachings, and providing resources and creating awareness. Working alongside health

care professionals, the emphasis on mental health should be equal to any other topic worthy of teaching and preaching about.

Post-Questionnaire Responses

The following are responses to the questionnaire following the presentation of each lesson. Question One: “Can you explain what you understand clinical depression to be and some of the key symptoms a person might exhibit?” There were significant responses, with most participants expressing a similar sentiment, including: “withdrawn, hopeless,” “isolated,” “feelings of hopelessness,” “depressed mood,” “despondent,” “sadness,” “low self-esteem,” “fearful,” “confused,” “dread.” Compared to the pre-questionnaire, the majority of participants reported the same answers after the four lessons. This indicates a consistent understanding of distress and its effects on individuals. While some responses were similar, it is evident that a deeper understanding was gained through the provision of researched information.

Question Two: “What are the signs someone has experienced or is currently experiencing clinical depression?” Not dissimilar to the post-questionnaire responses, there were fewer adjectives used to describe clinical depression compared to the pre-questionnaire, with the response receiving the most acknowledgment being: “withdrawn from friends and groups,” followed by feelings of “an inability to focus,” “missing work,” and “moody.” This demonstrates an enhanced and consistent understanding of what is defined as clinical depression. With a more specific understanding, this can lead to a greater impact on addressing distress.

Question Three: “How does clinical depression affect an individual mentally, emotionally, physically, and spiritually?” There were significant responses to this question. The most frequently given response, mentioned six times, was: “withdrawn,” “move away from church or anyone who recognizes it,” “may refuse help.” Again, the pattern is consistent, featuring fewer adjectives and a majority recognizing similar behaviors.

Question Four: “What distinguishes clinical depression from other types of mental health disorders? Have you ever experienced clinical depression? If yes, in what ways did you experience it, and for how long did you experience clinical depression?” The most common response acknowledged similarities and commonalities in their symptoms: “experienced clinical depression,” “not finishing school,” “weight loss,” “tired,” “poor sleep,” “lasted seven years,” “still deals with it at times,” “postpartum,” “troubling marriage,” “sad,” “despondent,” “let personal care go,” “lasted nine months,” “no meds,” “focused on the Lord,” “event driven,” “withdrawal caused depression,” “on meds fighting insurance company,” “better now,” “sustained and depressed mood.” The following was listed only once but offered significant insight: “may not require meds,” “not experiencing visual or auditory hallucinations,” “can usually be talked to,” “experienced family members with signs of clinical depression,” “needs meds and professional help,” “other disorders require medication,” “crying,” “couldn’t sleep,” “working excessively off and on,” “situational life triggered,” “diagnosed by a physician anxiety and panic can be a result of mental illness not treated by a physician,” “have chronic panic disorder,” “experience rapid heartbeat pounding,” “headache,” “a desire to run away,” “suffering over thirty years.” Most responses were personal, with some

coming from family members. Participants openly shared their own experiences, and some are still coping with distress. As their pastor, I was not privy to some of the situations participants faced. However, through this project relationships were built and enhanced, contributing to open discussion and comfort in sharing personal experiences.

Question Five: “What does the Bible say about clinical depression?” This question elicited many responses. Mentioned twice were: “pray about everything,” “show compassion,” “kindness,” “help them,” and “have a servant’s heart.” All other responses were singular with subtle overlap: “help those who are distressed,” and “It’s real and faith can help us overcome it.”

Question Six: “How can ministry be improved for those persons who have experienced or are currently experiencing clinical depression?” The most common response was “be a listener, be open, welcoming, not condescending, confidentiality.”

Journal entries

Following the presentation of each lesson, participants received journal questions for reflection. Some responses were lengthy, while others were shorter yet still demonstrated significant consideration for each question. Below are the summarized responses.

Week Two

Journal Question One: “From this story, where do you see applicability in your life? If none, explain.”

As participants heard the story of the Samaritan during the Biblical foundation presentation, their journal entries ranged from placing themselves in the narrative to identifying with specific characters and describing how they would respond if faced with similar circumstances. Most participants, while relating to the Samaritan, questioned whether they had the same capacity to step outside of themselves to address the needs of someone in pain. Others reflected on what the Bible teaches and the responsibilities that Christ calls everyone to follow. Below are their responses:

- “Do I have it within me to give selflessly to someone who is not even a relative or a friend but to give to a complete stranger because a stranger can be a neighbor? Yes, if I have the law of love, because their actions and showing love can cause them to seek Jesus.”
- “It’s applicable in everything I do, to be the person that is giving and loving, something that truly pours from the heart. If Jesus is in my heart, then we can truly help someone in need.”
- “I notice several similarities. I lead with my heart. I have the heart of a giver and am blessed with the gifts of helping; however, some people take advantage of that, yet it does not deter me.”
- “You cannot expect or count on the leaders of the church (pastors) to meet the everyday needs of the people. They should not have to do all the work. Even Jesus said only God was good.”
- “The Inn serves as a reference for the Church, the church as a hospital; I want to be part of a church like that. It is not acceptable to think or say someone else will probably help.”

- “I should show compassion to anyone. Treat everyone as a neighbor. My bias to help solve a problem is fear. One part of the story where I see myself is in my reluctance to give freely. I see applicability when I see my patients indiscriminately, regardless of race, social status, illness, etc.”

These responses conveyed a sincere desire to honor the teachings of Christ. As the participants immersed themselves in the story, they recognized what Christ requires, which is rooted in love. Any reluctance expressed stemmed from fear and a hesitance to freely give of oneself.

Week 3

Journal Question Two: What are your thoughts after hearing the discussion as it relates to how mental health (i.e., clinical depression) was addressed or not?

- “There are many components to mental health. Basic needs must be met before addressing spiritual matters. Doing God’s work to bring souls to Christ is not always clean and easy.”
- “I never knew the origin of the Salvation Army. The church should be a haven of a caring community, loving unconditionally. The Salvation Army has been a model in many ministries today as needs are met first. They saw, listened, and acted. The Salvation Army shows us that the church exceeds the walls of a building.”
- “Mental health is a broad spectrum with many contributing factors. In my opinion, the majority of mental health issues were caused or exacerbated by life circumstances—a breeding ground for sadness, hopelessness, low self-esteem,

unworthiness, isolation, and self-doubt brought out or worsened by difficult life circumstances.”

- “I think the most important human need is to be valued and to know that you matter to someone. This can lead to a lot of depression and anxiety. Most importantly, faith and hope in Christ are crucial. Meeting a physical need, or even an emotional need, opens the door to meeting a spiritual need.”
- “It seems that there was classism in the way society and the church treated those struggling as less than, with total disregard and no action taken by some. People were now connected and accepted, which alone can help mental, emotional, and spiritual health.”

The story of the Salvation Army resonated with the participants. Through its narrative, participants gained a deeper understanding of what is defined as mental health and how life circumstances contribute to it. Their responses demonstrated comprehension and highlighted how the church can address distress. As one participant stated, “The Salvation Army shows us that the church exceeds the walls of a building.”

Week 4

Journal Question Three: Does the church share any responsibility in addressing social issues and injustices, and how should it address/engage with these issues? If not, why not? Explain your answer.

- “Yes, the church is part of the entire socio-economic, political, and moral fabric of society and shares in the responsibility to the community.”

- “Jesus engaged in social issues. The church is supposed to help those who are sick, the lost, the shut-ins, and those in need. The Booths did this. It is the ultimate goal of every Christian to help save one another.”
- “As a church, we must step out of our comfort zone to help others in any way we can, leading with love and compassion. We should provide assistance with food and shelter, organize non-violent gatherings and group sessions, identify those with mental health crises, and connect them to mental health professionals while raising awareness through teaching and preaching.”
- “I strongly feel that the church bears responsibility. Knowing Jesus, His grace, compassion, and love give life meaning. The church has been woeful in addressing social issues and injustices. I believe mental health is a social issue and may even be an issue of injustice.
- “In my 43 years of primary care, the demand for mental health services in the healthcare system has increased dramatically. By the end of my career, as much as 50% of my day could be spent caring for mental health concerns. I recall looking at a list of the 10 most commonly prescribed medications, and five of them were for depression and anxiety. I feel confident that the stigma surrounding mental health has declined, especially among women and particularly younger women. Men have seen some change, but not as much. Nevertheless, the stigma still exists. Telehealth via video chat has not only improved access but also reduced stigma.”

- “The church should be at the forefront not on the sideline, recognizing the signs, coming alongside, listening, knowing warning signs, facilitating referrals, preventing suicide should be part of every church mission.”
- “Bringing mental health issues and their consequences to light may cause tension, but it can also lead to growth in the church. Training is needed.”

Responses to week 4’s journal entry were an emphatic yes! Participants expressed that the church should engage with social issues and injustice. Their responses illustrate the connectivity of the foundational lessons and how they relate to distress. Actions should be selfless, and responses suggest the church has been “woeful” in addressing these issues. As they considered the church's actions, their responses demonstrated a better understanding of mental health, using phrases that can help someone dealing with distress. Such phrases include: “coming alongside, listening,” “love,” and “compassion,” which indicate a deeper understanding as they listened to the lessons on mental health.

Week 5

Journal Question Four: How do the areas discussed over the past four weeks (Biblical, Historical, Theological, and Interdisciplinary) inform each other and affect the church specifically as it applies to clinical depression?

- “Biblical principles set the stage, the blueprint, while historical evidence demonstrates the longevity of service as Christ-centered followers and how the Salvation Army broke away to address a need in the community.”
- “Theological and interdisciplinary approaches highlight the importance of serving those in need, showcasing the compassion and human elements that constitute a

person. Additionally, it illustrates how the church and church leaders can engage and support individuals in need. More training and workshops are necessary to teach how to recognize signs in people they encounter.” “Simply showing that we care and are here to help is essential. "Five weeks of dialogue have reshaped my mind as a leader and reaffirmed another layer and level of servant leadership.”

- “These four weeks demonstrate a strong interconnection with one another and with mental health in the church. Biblically, love is emphasized; historically, the Booths learned by observing, listening, and addressing needs.”
- “There is a very strong connection between the study of the 4 weeks. What people need most, as SIT tells us, is people. They need to feel valued, respected, listened to, heard, and loved. Even if one has all basic needs met, they can still be isolated, sad, lonely, and thus depressed. What we learned from the Salvation Army is that people need basic critical life needs met to be in a good place to hear about Jesus. The Samaritan story tells believers to what extent we should show love to others. Church history speaks to the evolution of the church and its role in society. Bonhoeffer describes the church as the living Christ. My conclusion is that the church is in a unique position to address the symptoms of mental health and thus clinical depression.”
- “Stigma, access, cost, and fear of being judged or made to feel weak (particularly men) all play a role in people not seeking help. Training leaders and anyone willing to help involves learning how to observe and recognize symptoms, body language, what they say, prayer requests, etc. It requires critical, specific training to have a reasonable idea of when someone just needs a friend, someone to listen

and validate, and when it is more than that- even to the point of asking about suicide. Have knowledge of available resources.”

- “Biblically, people look past the needs of others. Some individuals are willing to meet those needs. History reveals classism, division, lack of resources, and a disregard for the needs of people outside of the church and various groups. Theologically, we should focus on what God says about how to treat others and His instructions regarding needs, which vary from church to church. SIT combines knowledge and integrates disciplines to address the problem and enhance understanding to find common ground. All four aspects are intertwined, interwoven, and interconnected. The church should be present; the Salvation Army has been a guiding light in times of need for the distressed, aligning theologically with biblical principles. Interdisciplinary approaches suggest that when individuals connect with others, they experience a sense of self-worth, purpose, and belonging. This connection aids their ability to cope with emotional or mental challenges, as they have others to lean on, rely on, identify with, and trust. Belonging can be both positive and negative; however, the benefits of belonging outweigh the detriments of not belonging. I agree that loneliness and isolation contribute to mental health issues, which correlate with low self-esteem and self-worth. I believe loneliness and isolation could also foster a stronger relationship with God. The bottom line is: I believe that if at least one of these four areas were to be present in someone's life, they would recognize when they need help. I think if a person has... all four of these areas in their life then their

mental well being is probably better than someone who doesn't have these.

Therefore, we need to at least offer help where we can, even outside the church.”

Participants' feedback summed up the foundational lessons by recognizing the connection in understanding mental health, specifically distress. As participants reviewed the four weeks of foundational lessons, their understanding of what Christ requires evolved, how historically an organization was able to step away from its initial agenda to address distress, the church's responsibility to social issues, and how issues of injustice require stepping outside of comfort zones to meet needs, along with the importance of relationships for the well-being of others. As one participant stated, “All four aspects are intertwined, interwoven, and interconnected. The church should be present; the Salvation Army has been a guiding light in times of need for the distressed, aligning theologically with biblical principles. Interdisciplinary approaches suggest that when individuals connect with others, they experience a sense of self-worth, purpose, and belonging.” The responses affirm that people experiencing distress may find relief if church leaders receive training. “Five weeks of dialogue have reshaped my mind as a leader and reaffirmed another layer and level of servant leadership.” Equipping ministry leaders can reduce distress by helping them gain the skills to improve the emotional well-being of others. These responses support the hypothesis that, “If ministry leaders are trained to recognize the signs of distress (anxiety and depression), then they will be equipped to exercise compassion and guide congregants to the help they need.”

Conclusion

Initially, when reaching out to potential participants for this project, there was uncertainty about who would be receptive. Since this project proposal included six to ten

participants the expectation was that about half of the invitees would decline, so invitations were sent to fifteen people. Surprisingly, everyone who received an invitation accepted. To remain faithful to the project proposal, ten individuals were selected based on those who submitted their signed consent forms first (one individual had to drop out due to a family emergency). No additional participant was added since the project had already begun, and including another person would not have given them sufficient enough time to review the statistical data that the other participants had previously received. As a result, only nine people participated in the study which still aligned with the 6-10 number submitted.

This project was conducted with members of JCC focused on the rise of mental health (i.e., distress), its effect on individuals, and whether trained ministry leaders would be a suitable place to aid in reducing the stigma associated with it. As subject matter was presented based on several modes of study (Biblical, Historical, Theological, and Interdisciplinary) participants were able to demonstrate understanding specifically of distress, its impact, and how they can come alongside those suffering to aid in alleviating the stigma providing meaningful support.

During six weeks of gathering insights on distress through biblical, historical, theological, and interdisciplinary subjects, ministry leaders exhibited engagement and curiosity. They asked questions and displayed a solid grasp of their leadership roles in the church, recognizing their potential to alleviate stigma and support individuals in distress. The presented information, combined with foundational papers, questionnaires, one-on-one interviews, and journal entries, underpins my hypothesis that, “If ministry leaders are trained to recognize the signs of distress (anxiety and depression), then they will be

equipped to exercise compassion and guide congregants to the help they need” and signifies that project participants (JCC ministry leaders) desire to and are eager to participate in education aimed at identifying its signs. This will enable them to more effectively recognize distress signals and offer appropriate guidance and resources.

Project Special Circumstances:

Factors that could have influenced the project included two members who were practicing physicians who had treated individuals experiencing distress. Knowing that there were physicians as part of the group could have caused others to be reluctant to share their views. However, this was not the case. While some participants were familiar with the terms “mental health and distress,” they lacked in-depth knowledge about other topics discussed, such as the historical data of the Salvation Army, the Church, and Social Identity Theory. This allowed everyone to gain insight from their interactions and participation with others. The questionnaires were completed anonymously, and the journals were also done anonymously. However, as one of their pastors, it was not difficult to discern some of the sources of feedback. This was both beneficial and detrimental. It was beneficial in that it provided an understanding of how individuals thought. However, identifying the respondents could have been detrimental, as having preconceived notions could have led to assumptions and distorted research results. Conducting some of the research anonymously was helpful in this case, as participants demonstrated comfort in expressing their views.

Knowledge of the varied occupations offered unique insights. However, church leaders might make assumptions about what people know, potentially overlooking or

misinterpreting their thoughts and experiences. This circumstance illustrates how personal relationships could be difficult to separate from the project. This situation instead provided an opportunity for additional learning. Furthermore, it is a perfect example of the study's point: that the church, through relationships, can be a place of support and belonging for those suffering from poor mental health. If this project is conducted again, care should be taken when working with familiar individuals to avoid making assumptions about their responses.

An example of this involved an encounter with a participant with whom there was a pastor-congregant relationship. However, through this process, quite a bit was discovered about her struggles and challenges that had been missed. During one of the project meetings, everyone else was very communicative, while she was somewhat shy and did not engage in conversations. Having previously served in corporate America in a management capacity and receiving extensive training in communication and effective listening skills, it was important to gather different perspectives during the group discussions. Therefore, calling on those who were less forthcoming during open discussions was a way of making them feel included and not overlooked. When asking this particular participant if she had any thoughts, she replied, “No, not at this time, but I’ve been taking notes; I have five pages just from today.” Although not much thought was given to engage her any further, another participant communicated that being called out made her uncomfortable. Yet, she wanted to be involved in the project and did not want any suggestion to leave the project team.

A few days later, during a church service, the quiet participant requested a meeting. In private, she shared that she suffers from depression, anxiety, and panic.

Additionally, she explained the methods she uses to address her symptoms, noting that some are successful while others are less effective. She wanted to ensure that she would not be asked to leave the project because she understood exactly what she was signing up for. Moreover, she sought to learn more to help others who might experience similar challenges as she does, both now and in the past.

It is important not to make assumptions about people and to listen more, not only with our ears but also with our eyes (which was the purpose of recording the Zoom meetings). In the conversation, she shared the insights she had gained during the first two weeks (since that is all that had been covered so far), and a new relationship began to form. It is vital to understand that silence does not mean someone feels excluded; it could simply be an inherent trait that supports the need for training. Furthermore, silence does not always indicate a mental health concern. This is concerning because, while listening and visual observations can effectively determine if someone is in distress, this is not always the case. Therefore, having a relationship with someone is also a way to recognize the signs of distress, as Social Identity Theory speaks to.

Now that a deeper connection has been established with this participant, her ability to engage in more profound conversations and her actions demonstrate the comfort she is gaining in sharing, as she has started to open up more and discuss some of her most personal concerns. This illustrates how the church can serve as a place where relationships are built and individuals can discover a sense of identity. Identity is important, but respecting a person's identity is paramount. While everyone is different, if we consider the role that love plays in every relationship, the biblical commandment suggests that regardless of who they are, love will seek to do what is best for everyone.

Project Reflections

From this project, there was a resounding affirmation that mental health is a topic the Church can and should address. Project participants gained a deeper understanding of Christian responsibility based on each foundational lesson. From the story of the Samaritan, participants learned that it is vital to care for others, and being a neighbor is not determined by proximity to living space, but rather by human compassion and a commitment to caring for everyone indiscriminately. This was further demonstrated through the efforts of the Salvation Army, which, while having one objective, recognized that there is more to salvation than merely preaching it; it involves living it out through acts of service. This highlighted how the Church, a community of believers, rather than just a building, embraces the mission of carrying out the will and commandments of Christ not only through preaching and teaching, but also through action. Christians are representatives of Christ who promote love, compassion, encouragement, and care to help alleviate the distress in others' lives. This means coming alongside people, doing what you can, providing resources, and serving as a guide when individuals face challenges beyond their abilities. Lastly, Social Identity Theory acknowledges that identity, while inherent, is also shaped by the people and groups one belongs to, and a lack of interaction with others can negatively impact mental well-being.

Throughout this process, project participants demonstrated a deeper understanding of mental health (i.e., distress) and articulated how the church can assist through education and a willingness to engage in initiatives that specifically support mental health. In particular, support for issues such as anxiety and depression can be

achieved. Based on the unfiltered responses over the six weeks, the project supports my hypothesis that “if ministry leaders are trained to recognize the signs of distress (i.e., anxiety and depression), they will be better equipped to exercise compassion and guide congregants to the help they need.”

While participants demonstrated a relatively accurate understanding of clinical depression, some responses could be viewed as pertaining to mental illness, particularly in relation to suicide. However, according to the National Library of Medicine, “Burgess and Hawton highlight the challenges psychiatry faces in addressing suicide. They argue that not all individuals who commit suicide are mentally ill and that mental illness is often not easily distinguishable from normal distress.”⁸ This indicates that if mental health training were provided in a church setting, it must be carried out meticulously, thoroughly addressing the risks involved in discussing an individual’s mental capacity. It should be emphasized that the church is not seeking to replace medically trained personnel, but rather to offer support that considers the entirety of human beings, including their physical, mental, emotional, and spiritual well-being. Through the journal responses, participants highlighted the interconnection among the subjects discussed, emphasizing the importance of this connectivity and how it should be considered in relation to mental health. They openly shared their personal experiences with clinical depression, including its effects on their behavior and the strategies they found helpful. Approaches for addressing mental health within the church suggested by participants included providing training, discussing mental health more openly to normalize the

⁸ Abdi Sanati, “Does Suicide Always Indicate a Mental Illness?” *London Journal of Primary Care* 2, no. 2 (2009): 93-4. doi:10.1080/17571472.2009.11493259

conversation, and reducing the fear of judgment. Participants recommended offering training that goes beyond sermons or teachings, focusing on understanding mental health and its impacts on individuals and the community. They believed such training could foster a deeper understanding that would facilitate change both within the church and throughout the broader community. Participants agreed that the church can serve as a space where individuals, united by common beliefs, feel free to connect and experience a sense of belonging rather than isolation and despair, ultimately aiding them in understanding their multifaceted personal identities.

These suggestions emphasized training and openness in discussions about mental health, which were invaluable as they intersected with the hypothesis that supports training to better understand the signs of mental health. Their responses further illustrate a willingness to gain more understanding and to create a place where individuals can feel comfortable sharing that they are not okay.

This project has taught the importance of research and is not meant to suggest that it is a cure or remedy for mental health, but rather a possible segue in normalizing discussions around it and opening the door for more individuals to receive help. Although there is a risk of missteps when discussing mental health, the positive impact of such conversations and training in the church will greatly surpass any negative outcomes. Regarding future work, the consensus strongly supports my hypothesis that “If ministry leaders are trained to recognize the signs of distress (anxiety and depression), then they will be equipped to exercise compassion and guide congregants to the help they need.” At the end of the project, participants expressed their desire to serve as a pilot site to test the hypothesis by receiving the suggested training, which involves identifying resources that

provide training related to mental health, developing a curriculum to teach other ministry leaders, and making this training accessible to churches worldwide. While this is an ambitious goal, it offers an opportunity to tackle the current crisis in mental health, promoting hope and holistic healing through the church.

APPENDIX A
MEETING AGENDA

MEETING AGENDA

Prior to the start date, met with identified context associates January 20, 2025-January 24, 2025

Finalized participant list and obtained signed consent forms January 30, 2025

January 31, 2025 – Project Start Date – Session 1- Distributed Pre-Questionnaire

February 6, 2025 – Session 2 - Zoom

February 13, 2025 – Session 3 - Zoom

February 20, 2025 – Session 4 - Zoom

February 27, 2025 – Session 5 - Zoom

March 6, 2025 – Session 6 – Live meeting, Journals collected, Project review, Post Questionnaire completed

Individual interviews were conducted via Zoom over the course of six weeks.

APPENDIX B

PRE- AND POST-QUESTIONNAIRE

PRE- AND POST-QUESTIONNAIRE

1. Can you explain what you understand clinical depression to be and some of the key symptoms a person might exhibit?
2. What are the signs that someone has experienced or is currently experiencing clinical depression?
3. How does clinical depression affect an individual mentally, emotionally, physically, and spiritually?
4. What distinguishes clinical depression from other types of mental health disorders? Have you ever experienced clinical depression? If yes, in what ways did you experience it, and for how long did you experience clinical depression?
5. What does the Bible say about clinical depression?
6. How can ministry be improved for those persons who have experienced or are currently experiencing clinical depression?

APPENDIX C
JOURNAL QUESTIONS

JOURNAL QUESTIONS

Week 2

From this story, where do you see applicability in your life? If none, explain. Identifying similarities to self compared with the story will show how their interaction or lack may affect others.

Week 3

What are your thoughts after hearing the discussion as it relates to how mental health (i.e., clinical depression) was addressed or not? Knowing what participants think will help determine whether the church is interested in incorporating this topic into church programs as a vital part of ministry or if they see it as a mental health issue that should be addressed only in a clinical setting.

Week 4

Does the church share any responsibility in addressing social issues and injustices, and how should it address/engage with these issues? If not, why not? Explain your answer. This can aid in determining if participants believe they have a responsibility in addressing mental health (i.e. clinical depression) and how.

Week 5

How do the areas discussed over the past 4 weeks (Biblical, Historical, Theological, and Interdisciplinary) inform each other and affect the church specifically as it applies to clinical depression?

APPENDIX D
INDIVIDUAL INTERVIEW QUESTIONS

INDIVIDUAL INTERVIEW QUESTIONS

1. What do you believe are the most challenging aspects of dealing with depression?
2. Are you comfortable interacting with persons who exhibit signs of clinical depression?
3. Do you think there is a stigma associated with mental health, specifically in issues like depression, and what are your thoughts relative to the church's role in helping to remove it?

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